

BIOLOGICAL COLLECTIONS
SERIALS

V. 1

A

1870

Columbia University
in the City of New York

College of Physicians and Surgeons



Reference Library



Digitized by the Internet Archive
in 2014

THE
AMERICAN JOURNAL
OF
SYPHILOGRAPHY AND DERMATOLOGY.

DEVOTED TO THE CONSIDERATION AND TREATMENT OF
VENEREAL AND SKIN DISEASES.

EDITED BY
M. H. HENRY, M. D.

SURGEON TO NEW YORK DISPENSARY,—DEPARTMENT OF VENEREAL AND SKIN DISEASES; MEMBER
OF MEDICAL SOCIETY OF COUNTY OF NEW YORK; HON. SEC. FOR NEW YORK OF THE
ANTHROPOLOGICAL SOCIETY OF LONDON, ETC., ETC., ETC.

Published Quarterly.
VOLUME I, 1870.

NEW YORK:
F. W. CHRISTERN, No. 77 UNIVERSITY PLACE.
1870.

THE AMERICAN JOURNAL
OF
SYPHILOGRAPHY AND DERMATOLOGY.

JANUARY, 1870.

Original Communications.

ON SYPHILIZATION.

BY W. BOECK, M.D.,

Professor in the University of Christiania, Norway.

WHEN, twenty years ago, the term syphilization was first used by syphilographers, the measure was regarded simply as a prophylactic against the contraction of syphilis.

Auzias Turenne,¹ the author of the method, whose experiments with animals had given him the idea of the method, first proposed to use it in a prophylactic way against syphilis. But to inoculate individuals with syphilitic virus when the virus had not already permeated every tissue is immoral. It is repulsive to every medical man. If, on the contrary, the constitutional syphilis is already present ; if the syphilitic virus is already permeating every vessel, then it is permitted to inoculate the same virus on the skin ; and it is the more admissible when we consider that it is to cure the syphilis.

It is the curative inoculation that I have always used, and it is for this only that I propose the term syphilization. Is it, however, possible by inoculation with a new primary syphilitic virus to cure constitutional syphilis ? will every medical man

¹ M. Turenne now only resorts to syphilization as a curative agent.

ask. And it is little more than twenty years ago that every man would have answered in the negative. I was myself an unbeliever, as I stood at the bedside of my first patient and subjected him to this treatment. But my observations from day to day convinced me that I must abandon my convictions, formed *a priori*. I saw, not that the organism was by many repeated inoculations additionally poisoned and destroyed, but that, on the contrary, my patient was daily growing better and better, and that all syphilitic symptoms were growing less and disappearing. This fact was to me sufficient, and I yielded to the lesson. I had now only to study in what way I could best carry out these inoculations. I observed already that it was inadvisable to commence any inoculations until secondary symptoms had already appeared. When they have appeared I commence my inoculations as soon as possible. I take the matter for my inoculations, whenever it is possible, from the indurated chancre, which in most cases must first be irritated in order to yield purulent matter, which alone is inoculable. I do not object to the use of matter taken from a soft chancre, as experience has taught me that the result is the same, and I am, from my diagnostic and curative inoculations, convinced of the unicuity of the virus of the two forms of primary sore. I take the matter on the lancet and inoculate precisely in the same manner as in ordinary vaccination, using, however, great care—since the inoculation of syphilitic virus does not take with the same readiness as does that of vaccine virus. I commence my inoculations on the sides of the chest, making three inoculations on each side. One inoculation would be enough were I quite sure that the virus would take effect, but it often occurs that some inoculations have no result. I therefore inoculate at several places. At the end of three days there are generally pustules developed after the first inoculations. I take matter from these and inoculate in other places on each side, taking care at each succeeding inoculation to inoculate at a sufficient distance from the former pustule to prevent anything like a union or confluence of the sores. I continue now in the same manner my inoculations on every third day, taking always my matter from the last pustules formed, until this matter has lost all effect. I then take matter from some other

patient, generally from a patient under treatment by syphilization. I continue with this new matter in the same manner as I did with the first. The second matter does not produce sores as large as the first, and cannot be inoculated through so many generations. When this matter also loses its effect, a third selection is tried. It is possible that this will prove effective, but not to any great extent. It is best at this period to commence over both arms. To commence the inoculations over the arms, new matter can be selected, or the matter can be taken from the most recent pustules of the chest, because the matter which produces no effect on the chest may produce pustules over the arms. I continue now on both arms in the same manner, and pursue the same course as I did over the chest; continuing as long as the matter shows any effect. When the effect on the arms appears to be lessening, I commence at the thighs, and continue there in the same manner as on the arms, until there is no appearance whatever on any of the inoculated surfaces of the existence of any matter. The reason I commence inoculations on the sides is, that I never find or produce any phagedaenic sores in this region, which might occur were I to commence on the arms or thighs. During the course of these inoculations the syphilitic symptoms gradually subside, and, as a rule, have entirely disappeared when the virus fails to produce any further effect. When they have not quite disappeared at this time they disappear shortly afterwards, without any further treatment.

Every physician knows that the general health of patients is very different at the time the eruption, or constitutional syphilis appears. In some cases it is good. In other cases there is an anemic condition and rheumatoid pains. In every case is syphilization carried out without any reference to internal remedies, and when the treatment is finished the general health is invariably good. The anemic condition disappears simultaneously with the syphilitic symptoms. As I have now, as concisely as possible, explained the manner of carrying out the method, I should explain some points more minutely, because in practice it may be necessary to go more into details. Sometimes the first inoculations do not take effect; this, however, will be ascertained in twenty-fours. This negative result

is principally seen in those who have strong eruptive forms of the disease, and especially with children suffering from hereditary syphilis. When no effect is observed after twenty-four hours, it is necessary to inoculate again, and to continue to inoculate daily until the virus has taken effect. We have then not only pustules after the last inoculation, but pustular sores, produced at those points of inoculation where there had previously been no evidence of its having taken effect. When the virus has commenced to take effect I continue to inoculate on every third day in the same manner as already described. As we advance in our syphilization, the inoculations often fail to take effect ; then we do not wait until the third day, but commence at once with fresh matter, and, as the case advances towards a cure, it is often found necessary to inoculate daily. If the inoculations are not repeated as directed there is a greater risk of relapse. Another point which I wish to explain regarding the failure of inoculations, is this: A patient suffering from any acute disease, such as pneumonia, pleurisy, typhus, hepatitis, etc., will fail to show any effect from the inoculation, even before any symptoms of acute disease have manifested themselves. Whenever there is any acute disease developing itself I immediately stop the inoculations ; commencing again as soon as the patient convalesces. This intermission of the treatment is unfortunate, for it increases the chances of a relapse. For the same reason I am unwilling to place under treatment women who are far gone in pregnancy. The inoculations never produce any results during the puerperal state.

As I have remarked, the syphilitic exanthemata and other phenomena gradually disappear under syphilization. It may occur, however, that new symptoms will appear during the treatment, such as exanthemata, iritis and pains in the articulations. The treatment, however, should be continued. Should iritis be observed, I merely apply atropine, but no other treatment, contenting myself with keeping the patient in a clear, light room, since, from experience, I believe the darkened room only increases the severity of the attack. I have already said that I treat children with syphilization. During the early years of my observations I treated adults only

by this method, fearing to subject children, particularly those new born, to it, fearing that the pustules and sores that would be produced would be so large, and so great a source of irritation, that their strength would be exhausted, and that they would sink under the treatment. On the other hand, my impression was that if the method was correct, there was no reason why the principle should not be applied at all ages. I commenced, therefore, and found that the pustules and sores produced on the young were only of a size in proportion to the age and size of the patient. The children placed under treatment all did well, with the exception of those already suffering from visceral complications, such as are often found in children with hereditary syphilis. No other difficulties were experienced in treating children than adults, with this exception—that it was found necessary to repeat the inoculation oftener and with more frequent change of matter, the matter in children not proving effective through so many generations. I have thus far spoken only of syphilization for those persons who have but recently manifested secondary symptoms, and who have not been subjected to any treatment. Syphilization is not the great remedial agent where the system has already been plied with mercury. We are uncertain whether the inoculations will show the same regularity as in those cases where no medicines have been given, and it is uncertain whether there may not be a relapse within a short time. From my experience, I am impressed that even in persons suffering from relapses under other treatment, no better course can be pursued than subjecting them to syphilization. But, since even after this method a relapse may occur, I seldom resort to syphilization in persons suffering from the disease of long standing, since its failure in these last-mentioned cases would assist, most probably, with some, in bringing the treatment into disrepute. Since, however, some of my readers may be desirous of testing the principle with cases of old tertiary forms, I would suggest the following course as the most practicable, according to my own experience. I have already mentioned that inoculations seldom succeed so well in patients who have already been treated with mercury. It is absolutely necessary to observe with great care whether the inoculations have taken, and, if

the result has been of a negative character, to inoculate again without delay, disregarding the general rule to wait until the third day. When the inoculations no longer produce any effect, even with new matter, and the usual time allotted to cases has not transpired, I prescribe for a few days the iodide of potassium, recurring again to inoculations, often with good results.

Shortly after the discontinuance of the inoculations, small specific excoriations will be observed about the throat and tongue, and in women, after the first menstruation, small mucous tubercles about the external genital organs. These symptoms cause us no uneasiness, and the only treatment we make use of is the application of a little nitrate of silver.

In the treatment of the artificial ulcers produced by the inoculations, no more is necessary to be done than with ordinary simple sores—viz., applying a little simple cerate on lint, which is changed morning and evening, or a little fine linen dipped in cold water. Over this, for the sake of cleanliness and comfort to the patient, a linen bandage is applied, which serves the double purpose of absorbing secretions and preventing the clothing from rubbing against and irritating the sores.

If asked the *modus operandi*, or reason why syphilization produces the results which experience shows, I can only say that I find the problem as difficult of solution now as in my earliest and first experiences.

During seventeen years I have daily practised this method of treatment, and during this time I have observed the facts here described. The fact of cure, like all others, we realize; the cause it is impossible to explain. Why does vaccination prevent variola? Why does quinine arrest intermittent fever? These facts are with us of such daily occurrence that no one pauses to ask the reason why. Syphilization being a new fact, the *modus operandi* is immediately demanded. It will, I trust, not be regarded as presumptuous when I tell my readers that I have formed an opinion, based on an extensive venereal practice of some forty years—for years adopting the mercurial treatment, at other times devoting myself to the suggestions of other syphilographers, and during the past seventeen years paying more than ordinary attention to syphilization as a means

of cure. Whether the theory that I advance be right or wrong, the facts are established. I may as well state in the commencement that I place syphilis in the same class as acute exanthemata. Experience teaches us that these diseases pass through a certain circle; and every attempt to break off or interfere in the natural course of the disease is an unfortunate interference with the laws which govern the organism. If the disease is permitted to go on uninterfered with, we see syphilis disappearing from time to time; and at times, in from four to six months the disease will have entirely disappeared, and the individual will be comparatively well. It may be well to remark that these results are not always obtained. Cases are not wanting to prove that under the expectant treatment the disease progresses rather than recedes. Where the disease does disappear, the relapses are frequent and often extremely severe. Where mercury is used, the disease, in most cases, disappears very soon—the symptoms very often disappearing in from three to four weeks—the physician and patient too often regarding this as an extremely happy result. Is this so? With this view I cannot agree. I can only regard it as an unhappy termination. To illustrate more fully: To entertain such an opinion would be similar to a physician's expressing satisfaction were he to witness the disappearance of a scarlatinal eruption after plunging an infant suffering from this disease into a tub of cold water. By the cold plunge we arrest the natural course of the scarlatinal disease; and by the use of mercury in the treatment of syphilis, we interfere with the evolution of the disease through natural laws. Nature, however, commands obedience to her laws, and holds sway. We see, as a rule, that ulcerations of the throat are again appearing. Nature selects these parts to bring forward the disease, and from these starting points to pass through the circle. Notwithstanding the constant efforts of nature to eliminate the disease, medicines, and particularly mercury, succeed too often in apparently crushing out the disorder. When syphilis is not permitted to take a natural course, the disease too often invades new parts—the osseous system; the nervous system, principally the brain; the liver; the spleen; the kidneys, etc. Syphilization is the method diametrically opposed to mercurial treatment. By this method

I do not, for a moment, pretend to arrest the disease, or interfere with nature in her own movements. On the contrary, my efforts are directed towards assisting her in passing through a course which too often is but imperfectly accomplished through her forces. Every one who follows syphilization from three to four months will have an opportunity to witness the phenomena attending the elimination of the syphilitic virus from the system. This series of phenomena is finished by the immunity of the patient from anything like syphilitic infection. This circle, or series, of phenomena is not exceptional, but is seen in every person subjected to syphilization; and it was this regularity in the appearances that first attracted my attention. It is from these distinct phenomena that we commence to study anew animal virus in general, which must, of necessity, be of great pathological interest. My opinion is that this physiological side of the question is the principal, and the curative effect against syphilis the secondary one.

But it is the curative effect of syphilization which every medical man is now most interested in. Desirous of knowing the advantages that this method possesses over the mercurial treatment, I do not propose to discuss simply my individual opinion, but to present the facts. These were evident to me as soon as I had commenced syphilization as a curative measure. I was at the time exceedingly fortunate in having access to the archives in Christiania, where not only were my own former experiences recorded, but those, also, of my colleagues and predecessors for some thirty years. These observations I have collected in a statistical form and published as *Récherches sur la Syphilis*. Christiania, 1862. It is to this work I shall refer regarding the relapses following a mercurial course of treatment. Three thousand one hundred and twenty-three cases were, during this time (thirty years), subjected to a mercurial treatment for secondary syphilis. The average duration of treatment was one hundred and twenty-six days. Of these three thousand one hundred and twenty-three cases, one thousand and thirty-six had relapses—a little more than thirty-three *per cent.* of the gross number. Many of these have had several relapses, so that the number of relapses has gone up to sixteen hundred and fifteen. Subsequently to

the publication of this work, I received continually additional data and evidence to prove the results even more unfortunate than I have stated.

The results and benefits of syphilization are not to be seen to the greatest advantage in this work, since the number of cases treated in this way and recorded there is too small. Two hundred and sixty-five cases had at the time been treated in the hospital, and, of these, twenty-seven have had relapses—about eleven *per cent.* Up to this time I have treated some twelve hundred persons, and, if I allow thirteen *per cent.* for relapses, I feel assured that I am within bounds. Most of these relapses were of a mild form, and of comparative insignificance. But few were of a more severe character, or assumed a tertiary form. I do not altogether regard the multiplicity of relapses as of very serious import, but look to the general health and constitutional habit of each individual as of the first importance. Towards this last view my attention has, during many recent years, been directed. Many of the most severe diseases, which every practising physician must meet, follow in the train of syphilis, such as diseases of the brain and nervous system in general, of the kidneys, the liver, the spleen. These diseases follow the treatment of syphilis by mercury more easily and sooner than by the non-mercurial treatment; and there is no treatment that seems to offer greater immunity against these dreadful results than syphilization. In contrasting these conditions, the few and mild relapses, the slight chances of subsequent suffering, and the general improvements in health, so much more plainly shown after syphilization than after the mercurial treatment, it seems to me to be the difference, as it were, between day and night. So thoroughly did I become convinced of these facts, that I have found myself quite unable to offer mercury in any form during the past seventeen years.

Before going further, it may be well to say something regarding children born of syphilitic parents, who have been subjected to syphilization as a means of cure. These newborn children are, after the syphilization of the parents, in a similar condition to that of the children of those who have been treated by other means—*i. e.*, if the mother had constitu-

tional syphilis *after* puberty, as a rule, the first, second, and sometimes the third child suffer from a syphilitic diathesis. If the father has had constitutional syphilis, the child may inherit the disease ; but this is rather the exception than the rule. This opinion is, I am well aware, doubted by most syphilographers. I have, however, simply recorded my own experience, and the results of my observations, and I am inclined to think that, at some future day, the experience of many of my *confrères* will lead them to change their views. My impression is, that a syphilitic woman is sooner likely to give birth to a healthy child, when treated by syphilization, than when treated by mercury ; and further, after the first child born in a healthy condition, she will, as a rule, continue to produce others in the same happy state.

From my explanations, my readers will see that I do not believe that syphilis is eradicated from the system even by syphilization, but that it is forced into a latent state ; the patient, however, being in a healthy condition, in contradistinction from those who too often show evidence of a broken down condition where mercury has been administered ; these last often dying at a very early age. If I am fortunate enough to attract the attention of my *confrères* by the publication of these experiences and explanations, I desire to assure them that I have only to ask that they follow strictly my course of operating, and not do, as many have, unfortunately, done, cease when the work was only half accomplished. The patient, in this way, is not only not benefited, but placed in a more serious condition than before. Many have attempted to modify the measure according to their own peculiar notions, and, having failed to accomplish the best results, have contented themselves with condemning the method, rather than admit the possibility that the failure was due to their own innovations. Many have feared that the method would be too difficult when applied in practical life, and particularly in private practice. Such is not the case. No treatment is more easily pursued, and certainly none is more satisfactory. The patient will tell you from day to day of his improvement, and, I doubt not, will well reward you by the expressions, at least, of his gratitude.

CONTRIBUTION TO THE STUDY OF CONGENITAL SYPHILIS.

BY W. H. VAN BUREN, M.D.,

Professor of Principles of Surgery, with Diseases of Genito-Urinary Organs, Bellevue Hospital Medical College.

THE scientific interest, always inspired by congenital syphilis, and its unsolved problems, arises from the grave necessity for accurate knowledge of the subject, which is daily felt by the physician in dealing with the tenderest interests of humanity. The serious and complex question as to the propriety of marriage, the best mode of rearing infected offspring, the chances of their ultimate and entire restoration to health, the remoter consequences of congenital poisoning, are some amongst the many difficulties which are yet awaiting the positive solution that science requires. This result is to be attained, not by polemical discussion and criticism of disputed doctrines, but rather by striving to see clearly and to note truthfully the facts which are daily passing before our eyes, content to sacrifice personal predilections, and to leave the result to the future. It is not given to every man to generalize, certainly not to generalize correctly, from insufficient data. But there are few practising physicians who cannot furnish the details of some facts which have fallen within the scope of their own observation and experience, bearing upon these unsolved problems; and it is from such facts as these that the science of the future is to be built up—slowly and laboriously, perhaps, but surely and certainly.

In this spirit I contribute the following history, which, al-

though meagre in some of its details, I have endeavored to relate as accurately as the circumstances have permitted :

At the age of twenty, B—— had chancre in Philadelphia, in the winter of 1854–55, for which he took mercury for three weeks, and was slightly ptyalized. The next year he had chancres in Florence. In the succeeding year he contracted gonorrhœa in Paris, which was followed by buboes in both groins, with suppuration on one side, and by warts. In the spring of 1857 he had chancre again, for which he took mercury for a month. In the autumn of 1857 he called upon me for an opinion as to the propriety of matrimony. The Florentine chancres had destroyed about one-half of the glans penis, and it was this deformity alone that occasioned the doubt in reference to which I was consulted, as I was told on inquiring as to the existence of any symptoms of constitutional syphilis. He had no anxiety on this score, having never been conscious of any secondary symptoms, and refused entirely to entertain the idea of constitutional infection, of which, indeed, he presented no external evidence, being apparently in robust health. I decided that the deformity of the penis was no impediment to marriage, and he declined any further examination. After this he was not exposed to the risk of any new contagion. In August, 1858, he married a perfectly healthy party, never before married, and, at the end of nine months and seventeen days, his wife was delivered of a healthy female child, who is still living, and who has always enjoyed robust health.

In June, 1860, a second female child was born, with defective development of the brain and spinal cord. This child, as far as I can learn, never manifested any of the ordinary evidences of congenital syphilis. It showed a great deal of tenacity of life, although idiotic and paraplegic, and died at the age of five, from the consequences of whooping cough.

In October, 1860, I was consulted in regard to the wife and the second child. The former, from the enjoyment of brilliant health at the time of her marriage, had become gradually pale, weak and emaciated, without obvious cause. She had nursed both of her children. I was unable to make out any symptoms of secondary syphilis save a characteristic ulcer upon the side of the tongue, of at least six months' duration ; she had

also a gummy tumor, the size of a hickory nut, in the left *labium majus*. These symptoms disappeared, and her health rapidly improved under the use of the bi-chloride of mercury and the iodide of potassium, which were continued for more than a year, and pretty regularly, as far as I can learn, under the supervision of a highly intelligent physician in a distant city.

In 1861 I was consulted by the husband for amblyopia, and referred him to my friend, Dr. Agnew, who recognized "ophthalmoscopic signs of *retinitis syphilitica*, of a mild type, and distinct indelible retinal lesions, such as patches of proliferated tissue and atrophy." These were the first evidences of constitutional syphilis he had manifested. These syphilitic lesions were also complicated by those of *amblyopia potatorum*. He was advised to use the bi-chloride of mercury, which he did, somewhat irregularly, for several months, and, as I satisfied myself at a later period with great benefit to his sight. This, indeed, he also recognized, for he resumed its use subsequently of his own accord, on several occasions.

In January, 1862, another child was born (a boy), who, as I learned from the family physician, in a letter dated April 9, 1862, "appeared quite healthy at birth, and continued so until three weeks ago, when an eruption made its appearance, complicated with excoriations around the mouth and nose, which gradually invaded the whole body, and was, in the writer's opinion, "decidedly syphilitic." He adds: "There are at present no marks of morbid action in the mother, but she has resumed the use of the corrosive sublimate, and is nursing the child." The boy was treated by the hydrarg. c. cretâ for a few weeks, and the symptoms detailed above disappeared, but he remained pale and delicate. In February, 1866, the beginning of his fifth year, he began to suffer from nocturnal pains in in both tibiæ, and this symptom was shortly followed by periosteal swelling, involving about three inches of the subcutaneous surface of both bones. He was brought to me in the autumn of this year, when I verified these symptoms, and ascertained, also, that the boy had been affected by complete paraplegia, which had continued but for one day, on two different occasions, and that he habitually suffered from irritability of the bladder, requiring to be taken up two or three times every

night. He had also frequent attacks of pains through the nose, at the base of the cranium, and elsewhere. I found enormous nodes on both shins, and another on the subcutaneous surface of the right ulna. He was pallid, irritable, dejected, easily fatigued, dainty and capricious in his appetite, and sleeping badly from nocturnal pains. No specific treatment had been employed since the first three months of his life.

The mother was in apparently perfect health, with an excellent color and robust appearance, and had been in this condition for three years. The first born daughter, whom I also saw at this time, was a model of health. The boy was subjected, at once, to the systematic treatment of cod liver oil and the iodide of potassium, in doses of two grains, afterwards doubled. All of his symptoms gradually disappeared within the month, and he left the city immensely improved in appearance and strength, some prominence of the tibiæ alone remaining. After this the remedies were employed irregularly, and he became more delicate again. At the period of second dentition, I learn from his dentist, in a letter dated October, 1869, that he found "unmistakable evidences of the disease upon his incisor teeth, the development of the enamel quite imperfect—in fact, what I call syphilitic teeth."

About this date the father again came under my observation, suffering from irregularly nodulated and tender shins, superficial ulcers at the angles of the mouth, a yellowish patch on one tonsil, and a circular scaly spot as large as a sixpence on one of his palms. He had been exposed to no new infection. These symptoms commenced to yield promptly to mixed treatment. His general health is vigorous.

I learn that another child was born to him in October, 1867, the mother's health having continued excellent up to this period, when an ovarian enlargement was detected, which led to a fatal complication in the form of peritonitis, some weeks after delivery. This child survives in excellent health, having shown no evidences whatever of disease. The boy, now seven years of age, is still delicate, suffering occasionally from pains in his legs.

In this history, a sound, healthy woman is married to a man of unusually vigorous constitution, certainly affected with the

syphilitic diathesis, but not aware of it, and they have four children. The first is healthy, the second idiotic, the third syphilitic, the fourth healthy; the mother having acquired the disease, and anti-syphilitic treatment having been employed, by which she was apparently cured, the father showing evidences of the disease. The mother acquired the disease during the first pregnancy and lactation, and, as the child is healthy, this contamination was probably an example of direct secondary contagion, the alternative being that she was poisoned by a child who has never shown any evidences of disease. The second child was born, both parents now suffering from the disease, with arrested development of the cerebro-spinal axis, but showing none of the ordinary evidences of congenital syphilis. Was this arrest of development due to the syphilitic poison?

A third child was born after both parties had been subjected to anti-syphilitic treatment, but apparently not to an extent to save their offspring from infection. The disease in this child, assisted by treatment, passed through its secondary stage, to reappear four years later in the tertiary form; and here it assumed that somewhat rare phase of infantile syphilis in which the osseous system is involved.¹ It is noticeable that in this child there has been no sign of scrofula.

After further perseverance in anti-syphilitic treatment, the mother seems to have passed through the tertiary stage of the disease, and, apparently, to have recovered her health entirely. The father, less steady in the use of remedies, is not so happy, having manifested, still later, advanced secondary symptoms unmistakable in character. Under these circumstances another child, in all respects healthy, is born to them.

It is worthy of remark that the father, with no obvious signs of syphilis, or even of cachexia, communicates to the wife disease with marked cachexia, which rapidly runs into its final stage and apparently gets well; the diathesis more firmly established in him, yet milder and more chronic in its subsequent manifestations, still persisting. Also, that the mother, with

¹ A case which I observed in 1853, of congenital syphilis involving the osseous system, has been recorded by my friend, Prof. Bumstead, in his excellent work on venereal diseases, p. 465.

tertiary symptoms, gave birth to a son who had secondary symptoms, the father having not yet passed the secondary stage ; and that his son had, subsequently, tertiary manifestations. Finally, that the mother had no abortion nor miscarriage, and nursed all her children.

ON SERPIGINOUS TUBERCULAR SYPHILIDE.

BY R. W. TAYLOR, M.D.,

Surgeon to New York Dispensary—Department of Venereal and Skin Diseases.

MANY interesting features in the clinical history of this late lesion of syphilis, present themselves in the study of the three following cases. Being one of the tardy eruptions, it observes a comparatively definite period of evolution, passes through well-defined stages, follows a protracted course, and leaves extensive and indelible cicatrices upon the parts it has invaded.

We find it described and figured by various authors, among whom there are discordant views as to nomenclature. It is the *syphilide tuberculo-crustacée-annulaire*¹ of Ricord, whose figure of its declining stage is admirable; the *syphilide tuberculo-serpigineuse-cutanée* and *sous-cutanée*² of Danielssen and Boeck who also illustrate its late stage; Bazin, who gives a good description of the lesion, names it *syphilide tuberculo-ulcereuse-serpigineuse*; ³ Hardy calls it *syphilide ulcéreuse-serpigineuse*,⁴ and Rayer, whose description is praised by Bazin, simply calls it *syphilide serpigineuse*.⁵

Recently, Dr. Damon, of Boston, has published an illustration of it in his series of photographs, and calls it *Rupia Annulare*. The name prefixed to this article expresses concisely

¹ Clinique Iconographique de l'Hôpital des Vénériens.

² Recueil d'Observations sur les Maladies de la Peau, plates v. and vi.

³ Leçons sur la Syphilis et les Syphilides, p. 352.

⁴ Leçons sur la Syphilis et les Syphilides, p. 202.

⁵ Maladies de la Peau. Tome second, p. 410.

the whole character of the lesion—its origin in syphilis ; its occurrence in the tertiary or gummy period, in the word tubercular ; and its ulcerating and creeping tendency, in the word serpiginous.

Case I.—C. P., male, negro, married, 34 years of age, had initial lesion in the Summer of 1854, followed in the Autumn by secondary symptoms—a pustular eruption, sore throat, iritis, and nocturnal pains. In the following year he had various relapses of the rash, which was of severe pustular form, and has left cicatrices on the legs and the flanks. He then had a respite until 1861, when he had severe ulcerated throat, so that his food regurgitated through the nose. This was followed by ozaena. In consequence of the lesion in the throat, I find now a loss of the velum and of the pillars of the fauces, and the buccal and pharyngeal cavities have not their normal partial separation. He then had another respite until the Summer of 1868, when he noticed a pustule over the spine. This ulcerated very rapidly, so that, when first seen by me, in July, 1869, it presented formidable proportions. It was an irregular oval ring of dark green crusts, extending from the eighth dorsal to the fourth lumbar, spinous process, and on either side of the median line, to the extent of three inches, giving a vertical measurement of eight and three-quarter inches, and a transverse measurement of seven inches. The enclosed area of tissue could not be called a well-marked cicatrix ; it was mottled in color, somewhat thickened, and less supple than normal integument, giving, to close observation, the idea that it had undergone pathological change, but not as profoundly as in case No. 2. This condition is shown in Boeck's plate No. vi., where it is called *Syphilide Serpiginouse-cutané*.¹ The patient's health had always been good ; he had married in 1859, and had healthy children, with the exception of one, who has a few nummular patches of psoriasis upon one knee. He was treated with scruple doses of iodide of potassium three times a day, and the crusts dressed with simple ointment. He improved under the treatment. The ulceration which was in progress in one segment, ceased to extend, many of the crusts fell, and the

¹ Opus cit, plate vi., and text.

furrow granulated. To avoid repetition, the appearance of the ulcerating furrow will be described in the case following.

Case II.—A. McC., widow, domestic, 44 years of age, contracted the initial lesion from her husband, in 1854, which was followed by secondary symptoms. In the Winter of the same year she suffered from persistent nocturnal cephalalgia, and the next Spring had an eruption on the forehead around the margin of the hair, which has left small cicatrices. She then had no manifestations of the disease until 1859, when she noticed a small tubercle upon the prominence of the shoulder. It ulcerated and crept slowly down the arm, and ceased just below the elbow-joint; then it spread laterally, and involved the whole integument, investing the arm from shoulder to fore-arm. It now consists of thick cicatricial tissue, and upon it, in spots, is developed the neoplasm known as false keloid. The elbow-joint is somewhat flexed by tough cicatricial bands, and the limb is unwieldy and its motion impaired. The time occupied by this process was three years, in which temporary cessations took place. The same ulceration began upon the anterior walls of the thorax, and has converted the integument, covering it, into a vast expanse of cicatricial tissue, studded with tubercles of false keloid. This was accomplished in about four years, and was followed by an extensive ulcer upon the outer aspect of the right knee. She then had a respite from 1867 till the Spring of this year, when ulceration commenced on the outer aspect of the left knee, and she applied to me, at the New York Dispensary, in July. It was an irregular ovoid, in vertical measurement seven inches, with a transverse diameter of three and a half inches. It presented the typical characters of this lesion in all its phases. The upper margin was composed of very elevated, firm greenish-brown crusts, about half an inch in breadth. They were broken in places, so as not to form a continuous segment of a circle. They could not be very readily detached, and under them was a nearly cicatrized surface. Where the surface was free from crusts, the line between healthy and morbid tissues was very apparent. The lateral segments were not as far advanced in the reparative process. The crusts were somewhat broader, flatter and darker, and only slightly salient;

and further down still they were slightly below the level of the skin, as if sunken in a furrow. These lateral incrustations, moreover, preserved a continuous line. In the lowest segment of the ulcer, which was below the head of the fibula, the features were entirely different, as the morbid process was there in an active state. There was a continuous semi-circular furrow of ulceration, in width about half an inch. This furrow surrounded the ill-defined margin of the cicatrix, and was itself bounded externally by a sharply-cut, everted, reddened lip of derma, the redness of which was confined to a breadth of about one line and a half, and definitely circumscribed. The furrow was deepest under the everted lip, and could be plainly appreciated on passing a probe beneath. In the uppermost part of this ulcerating furrow—that part continuous with the lateral segments—mere films of pus had concreted. These were continuous with the depressed crusts already described. Thus we could trace the formation of the crusts from a mere film to the sunken condition—from this to their salience. All the features of the ulcerative process were here before the eye. At first sight, to those unfamiliar with the lesion it might not have been clear what was the relation of the varying conditions there presented; but close observation showed that in the lowest parts of the furrow the ulcerative process was active, with no reparative tendency. As a consequence, pus was abundant, and escaped. Further up, the healing process was gradually going on, granulations were forming, the pus was less copious and more inspissated; consequently crusts had formed, and their greater or lesser degree of salience depended upon the condition of the furrow. As that granulated and filled up, the crusts rose correspondingly. Furthermore, the older the crusts were, the more brittle they became by desiccation. During three years the patient had not had any treatment, and, when first seen by me, was very cachectic. She was given scruple doses of iodide of potassium, with five grains of citrate of iron and quinine three times a day, and the ulcer dressed with a five-grain solution of permanganate of potassa; and now, after the lapse of three months, is benefited.

The ulcer has undergone considerable change. The everted

lip has sunk down to the level of the integument, the furrow has been nearly filled with healthy granulations, and is covered with soft crusts, which will in time resemble, in all respects, the most ancient ones. The lip, no longer everted, has now become the boundary line between the enclosed eicatrical tissue and the normal integument.

Case III.—J. C., Irish laborer, 36 years of age, had regular evolution of symptoms eight years ago. He was a patient at Dr. Draper's clinic for diseases of the skin, at the College of Physicians and Surgeons, and through Dr. Draper's courtesy I report the case. This man noticed, one year previously, a small lump on the anterior aspect of the arm, which ulcerated until it involved the arm from shoulder to forearm. When he presented himself the ulcer was in its declining stage, being merely an oval red eicatrix, surrounded by a ring of typical crusts. He also was treated with large doses of iodide of potassium, and when I saw him last there was no new focus of ulceration. He never had been in any measure cachectic. The case is cited to show the period of evolution in the seventh year of the disease, the tubercular origin of the lesion, and the absence of cachexia. I have notes of two other cases, the noteworthy features of which were the evolution of the lesion, respectively in the fifth year of the disease; the origin of the one in an ulcerating gummy tumor, that of the other in a tubercle.

Most of the existing iconographie illustrations of the lesion are of its declining stage, which fact has given rise to the discrepancy in nomenclature. The name applied to it by Dr. Damon—*rupia annulare*—is very apt to mislead, as it conveys the idea of an anomalous case of rupia. Not to enter minutely into the clinical history of rupia, or, as it is more expressively named, *pustulo-crustaceous syphilide*, it may be stated that, generally, it is a late secondary lesion; that it may be precocious or tardy. When precocious, it is developed symmetrically; when tardy, as a rule, unsymmetrically; whereas the lesion under consideration has, for a syphilide, a tolerably well-defined period of evolution. A rupial ulcer increases at its periphery, and its whole surface is covered by a peculiar conical

crust. Serpiginous tubercular syphilide also increases at its periphery, but the incrustation is confined to that portion.

The focus of ulceration of this syphilide may be a tubercle, a pustule, or an ulcerating gummy tumor, and in its early stage the ulcer is not characteristic; it then appears merely as a flat crust, covering a circular ulcerated patch. This, however, very soon becomes better defined. The ulceration at the periphery increases in activity, while, in the centre, granulations, which have formed under the crust, become glazed very soon, the central crust falls, and we have an islet of cicatrization, surrounded by a furrow of ulceration. In six months the ulcer may have attained a diameter of nearly three inches, and in this stage increases at its whole margin; consequently it is generally round. It sometimes happens that two ulcers form in close proximity, and in course of time merge into one very large ulcer. As it attains size, however, the ulcerative process in some segments of the circle, or ovoid, is active, in others it wanes, and thus are produced those irregular, gyrate ulcers sometimes seen. In some instances, on the margin of a large circle, the ulceration forms segments of smaller circles, giving the whole a festooned appearance, which some imagine to resemble letters of the alphabet. The cicatrices left by this lesion vary considerably, according to the depth of the ulceration; and this has led Danielssen and Boeck to describe and illustrate two varieties, calling one *sypilide tuberculo-serpigineuse-cutanée*, the other *sous-cutanée*. As they are varieties in degree, rather than in kind, I have preferred, for simplicity, to describe both under the same name. The one, the cutaneous variety, is well shown in Case No. 1, while the subcutaneous variety is illustrated by Case No. 2. The cicatrix of the negro, as before described, gave evidences of considerable structural alteration of the derma, though in places its chromatogenous function had not been wholly impaired; whereas, in Case No. 2, the rough and uneven appearance of the cicatrices showed plainly that the whole thickness of the derma had been involved.

When the cicatrices are situated upon the flexor aspect of joints, the symmetry and mobility of the limb are very often much impaired by the development of large, tough bands.

The fact of spurious keloid being developed upon cicatrices deserves especial mention, as it is considered by Bazin to be peculiar to the cicatrices of *scrofulides*, which are more generally known as varieties of lupus. The clear syphilitic history of Case No. 2 precludes at once the idea of any other origin of the lesion and of its coincident neoplasm. And, furthermore, the well-known fact that spurious keloid is often seen upon other cicatrices, as those of burns, small-pox, amputations, &c., proves it not to have a specific origin. The cicatrix increases, *pari passu*, with the ulceration, and is not sharply cut, but merges insensibly with the ulcerating furrow, which bounds it. It loses its redness from centre to periphery, and becomes blanched in about a year. Sometimes, in very ancient ulcers, the cicatrix is white in the centre before its margin has ceased to spread. It is almost needless to state that this white shining cicatrix is indelible, and that, as years advance, it becomes thinner and depressed, as the subjacent infiltration is gradually absorbed. Sufficient description has already been given of the circumferential furrows and its lip, but it should be stated that in Case No. 1 they were not quite as well marked as in Case No. 2, though the process was analagous.

Observation has shown that the anterior aspect of the limbs, particularly near the joints, the shoulder, the back, and more rarely the face, are its usual sites of election. Reported cases are not sufficiently numerous to enable one to say authoritatively with what rapidity these ulcers advance. It is interesting to note how rapid was the course of the ulcer in Case No. 1, and also that in Case No. 2 the last ulcer, which was as large as the cicatrix on the right leg, attained its present size in eight months, and while prototype ran a slow course of three years. The patient, however, was in better health when the first was in progress than she had been lately. Another of these ulcers, which I have recently seen, was situated upon the back, and was nine inches long by six wide, and has occupied three years. This lesion is not always accompanied by cachexia. It may be generally stated to exist in half the cases. And there certainly can be no doubt that where it is intense the ulceration increases more rapidly. The result of all observation seems a warrant for classing this as a lesion of the third

period of syphilis, and I am not aware of any record of its precocious evolution. In my own cases the dates of its appearance were from the fifth to the fifteenth years. It is rarely painful, and only so when near the joints.

The diagnosis of this syphilide is generally easy, particularly in its encrusted stage. It might be mistaken for *serpiginous chancroid* or *serpiginous lupus*. *Serpiginous chancroidal ulcers* generally originate in virulent buboes or some points of inoculation. They have an irregular fungus surface, and very thick bluish-red and undermined edges, extend very irregularly, and in some parts are covered with an adherent slough, and the pus is auto-inoculable; whereas, besides a history or corroborating symptoms of syphilis, the *serpiginous tubercular syphilide* has its well-defined characters, and its pus is not auto-inoculable, and is amenable to constitutional treatment. *Serpiginous lupus* has not generally a history of any constitutional taint; its ulceration is erratic in its course; its crusts are of a light yellowish-brown, and irregularly scattered, and its cicatrix is thick and traversed by white seams, and it is not influenced by constitutional remedies.

The prognosis of *serpiginous tubercular syphilide* is, in general, good, as it rarely, if ever, compromises life. It is, however, unfavorable when it co-exists with the visceral lesions of syphilis and their cachexia. Its ulcerative process is, in some instances, very protracted, and by its unsightly cicatrices it may much disfigure and annoy the patient.

And now regarding the treatment. It cannot be too forcibly insisted upon that we must not rely too exclusively upon specifics. It must be borne in mind that the lesion originates in cachexia, whether perceptible or not, and that all our measures be directed to improving the general condition of the patient. Ferruginous and nervine tonics, like the citrate of iron and quinine, are very useful adjuncts to the specific action of large doses of the iodide of potassium, while, also, the regimen of the patient should be sedulously guarded. In the ulcerating stage, diluted Labarraque's solution, or five-grain solutions of the permanganate of potassa are very efficacious for their antiseptic and slightly stimulating qualities. Whenever in the encrusted state, any bland and emollient ointment will greatly re-

lieve the rigidity sometimes produced. In the event of flexion of a limb by cicatricial bands, it might not be unwise to direct the patients, as far as they can, to resist the contraction by constant extension.

Since the above was written I have had an opportunity of observing, with my colleagues, Drs. Henry and Foster, an unusual accident occurring in the cicatrix of this lesion, which was of very large size, and situated upon the back. In consequence of indulgence in habits of drunkenness and debauchery, the patient had become very much debilitated, and applied at the New York Dispensary for relief. The cicatrix, which patient descibed as having been perfect, showed rapidly progressing ulceration in the centre, and which observed none of the usual features. He had, also, deep ulceration in the throat.

ON THE USE OF THE ENDOSCOPE IN DIFFICULT STRICTURES OF THE URETHRA.

BY ROBERT F. WEIR, M.D.,

Surgeon to St. Luke's Hospital, etc.

THE following cases are presented as an evidence of the value of the endoscope in the treatment of a variety of strictures that are not unfrequently met with in surgical practice, and wherein a failure to pass an instrument into the bladder would probably necessitate external perineal urethrotomy, without a guide, confessedly one of the most difficult operations in surgery.

Case I.—J. N. H., aged 23, was admitted into St. Luke's Hospital June 27, 1867, with a very tight sub-pubic inflammatory stricture, of eighteen months' duration. At the time of admission the patient was in poor condition, and suffered greatly during micturition, the urine escaping by drops. On the 30th of the same month, after having made several unsuccessful attempts to pass the stricture, the endoscopic tube (size 13, English scale) was introduced, the patient being in a recumbent position, and a view of the stricture obtained, by means of sunlight illumination. Just anterior to the face of the stricture, which presented the usual pearly appearance, was seen a blood-stained dot, that marked the entrance to a short false passage. By first crowding down the end of the tube firmly upon the surface of the stricture, and then making traction by grasping the penis tight enough to prevent the tube slipping, a funnel-shaped depression was formed, into the bottom of which a No. 1 (French scale) Bénas' bougie was passed

and there held while the endoscopic tube was withdrawn. The bougie, being thus supported by the urethral walls, was then readily passed into the bladder, and there retained for twenty-four hours.

The subsequent treatment by intermittent dilatation was interrupted by the occurrence of frequent chills, etc., and the patient left the hospital, to return August 14th, when a No. 1 flexible conical bougie would be passed. On the 17th the patient was etherized for the performance of Holt's operation, but the conducting bougie to that instrument (adapted to Holt's instrument from Maisonneuve's urethrotome by Bumstead¹) failed to pass into the bladder. After several ineffectual trials the operation was postponed until the 22d inst., when it was proposed to use the endoscope should this difficulty be again encountered. At that time the stricture remained impassable until the endoscopic tube was used in the manner described above. By its aid the conducting bougie was introduced and the operation successfully concluded.

Case II.—J. M., aged 30, was brought, during the night of the 26th of May, 1868, to St. Luke's Hospital, for the relief of a retention of urine, which had existed about ten hours. The stricture causing this resulted from a fall astride a beam, which occurred nearly five months before, and was attended by the usual symptoms of laceration of the urethral wall. Several vain attempts had been made to relieve him, both before and after his entrance into the hospital. When seen by me at 11 A. M., he was suffering a good deal, and his bladder could be felt distended above the pubis, though he stated he had passed a little water when taking a hot bath at 7 A. M. Not succeeding by the usual means in passing the stricture, I inserted an endoscopic tube (Warwick's) to the seat of obstruction. After wiping away some blood that obscured the vision, there was seen, on the right side of the urethra, apparently about one-quarter of an inch anterior to the reddened face of the stricture, and partially overlapping it, a wine-colored mass the size of a small pea, and looking like a sessile polypus. This was speedily recognized to be a portion of the swollen

¹ American Journal Medical Sciences, October, 1868.

mucous membrane that had been torn up in the previous manipulations. By spirally crowding the end of the tube onward, this projection was forced back and the entire stricture brought into view. By the same procedure as we adopted in Case I., a very fine bulbous whalebone bougie was passed into the bladder, left there a few minutes and then withdrawn, and the patient thereupon voided urine. The stricture was subsequently split by Holt's instrument, and rendered capable of admitting No. 17 sound.¹

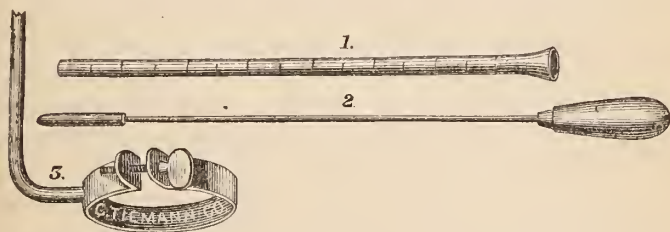
Case III.—J. L., aged 53, was admitted into St. Luke's Hospital July 20, 1868, with a tight inflammatory stricture, situated at five inches from the meatus, and of four years' duration. His urine was passed guttatum. Subsequent to his admission I made a number of attempts to get through his stricture, but failed completely, until the 31st of the same month, when he was sent to my office for endoscopic examination. By means of a No. 10 tube, necessitated by the small size of the meatus urinarius, the stricture appeared of a mottled red and white color, which was due, probably, to the bougies that had been used. There was no false passage nor granular points to be seen. The conducting filiform bougie of Maisonneuve's urethrotome was then engaged by traction upwards of the penis in the resulting depression of the urethra, and, after the withdrawal of the tube, was pushed in about an inch—*i. e.*, to the full diameter of the instrument—but could not be passed further. It was left in situ half an hour, and at the end of that time it was pushed on into the bladder, where it was left, and the man sent back to the hospital. Three hours subsequently, internal urethrotomy, by Maisonneuve's method, was performed, and No. 14 sound introduced, the meatus having first been enlarged.

Case IV.—Aged 22, entered St. Luke's Hospital (service of Dr. Buck) April 19, 1869, with an inflammatory stricture in the bulbous portion of the canal, and of three years' standing. He had also a fistula in perineo. On the 21st he was etherized for the performance of perineal urethrotomy without a

¹ The sounds referred to in this article are numbered according to the English scale, the bougie's according to the French scale (Charrière).

guide, previous attempts having failed in passing through the stricture. Before beginning the operation I was requested by Dr. Buck to make a trial with the endoscope. By resorting to the manœuvre already described, without, however, waiting to view the stricture, I succeeded in introducing a very fine whale-bone bougie, which much simplified the subsequent operation.

The endoscopic tube best adapted to the exploration of the urethra is delineated in Fig. 1. It is made of hard rubber, with a proper obturator, or plug (Fig. 2), to facilitate the in-



troductioin, and may vary in size from No. 10 to No. 13 of the English scale. It is also graduated in half inches on its exterior. For the examination of the antescrotal portion of the urethra, shorter tubes are of service. These tubes I have found preferable to the metallic ones used by Desormeaux and Cruise, being lighter, of a uniform blackness in the interior, and especially in their having blunter edges. For, although in investigating the urethra the tube is first introduced with the obturator to the deepest part, and the canal then viewed as the tube is slowly withdrawn, yet it is frequently necessary to carry the instrument backward again for the purpose of re-examining a suspected part. To do this with a metallic tube will generally, unless the obturator is re-inserted, cause, by its thin edge, considerable pain, and sometimes bleeding. The rubber tube, however, can be moved up and down the canal without pain or injury, and thus permits an appreciation of the condition of the urethral walls in the retrograde movement, by which revelations of importance are frequently made.

As Cruise's lamp, though superior in illuminating power to Desormeaux's, is decidedly unwieldy, and, moreover, expensive; in 1865, after many experiments, I ascertained that by attaching, by means of a simple clamp, with a standard (Fig. 3)

Tobold's laryngeal condenser to an ordinary lamp, or to an atmospheric lamp¹ burning kerosene oil, to which was added gr. x-xv. of camphor to the ounce, as suggested by Cruise, a sufficiently intense light could be obtained, which, when placed on a chair by the side of a patient, could be readily reflected to the bottom of the tube by Tröltsch's ear mirror. In using sunlight, by which a more natural view of the parts is gained, the light is generally directed athwart the patient by an ordinary plane mirror on a universal joint (a heleostat being unnecessary), and thence, by Liebreich's ophthalmoscopic mirror into the urethra.

With Warwick's endoscope—a silver tube, polished on the inside—simple daylight, or the light of an ordinary Argand burner, condensed by the ear mirror, answers very well in some instances, and was used in Case II.

For absorbing fluids, such as pus, oil, urine or blood, that may collect at the bottom of the tube, or for making applications of astringent solutions, etc., bits of cotton, fastened by twisting to the common uterine cotton-holder, suffices.

With these simpler means of examination the endoscope has been of service, not only in the treatment of difficult strictures, but also in the detection and treatment of several varieties of urethral diseases, such as granular urethritis, slight thickening of the walls of the canal, not recognizable by the *bougie à boule*; urethral chancres, and in chronic inflammation of the prostate. I may remark here that experience has also shown that granular urethritis, when found, should not be considered as the sole cause of a gleet, since, after its complete removal, the discharge will often be found to persist.

While considering the endoscope of considerable value in diseases of the urethra, I have been compelled to abandon its use in affections of the bladder, believing that the information that it affords does not compensate for the pain and subsequent irritation caused by its introduction and necessarily long retention in the bladder during the exploration and the prepara-

¹ This lamp has no chimney, the necessary draught being made by a current of air forced upward alongside of the wick by a simple clock-work in the base.

tory injection of warm water. That a clear view of a small portion of the trigone can be obtained, however, is acknowledged.

ON URETHRAL CHANCER OBSERVED BY DES-ORMEAUX'S ENDOSCOPE.

BY E. L. KEYES, M. D.,

One of the Surgeons to Bureau of Out-Door Relief, Bellevue Hospital.

J. B., UNMARRIED, 26, presented himself, December 4th, 1868, to be treated for his first attack of gonorrhœa, which attack, he stated, had commenced exactly four weeks before, and for which he had as yet undergone no treatment. The patient had been last with a woman five weeks before (latter part of October, exact date forgotten), having previously indulged in no sexual intercourse for three weeks.

I found a rich creamy discharge flowing from the meatus, history of smarting on urination, &c., &c., and gave the case but little attention, prescribing the ordinary balsamic treatment. The inguinal glands were not examined. December 21st, patient reported cured and was discharged, being advised to continue his medicine. December 28th, patient again presented himself, to say that his discharge had returned, but that it was no longer thick, as formerly, being now transparent, watery, and slightly sticky. Ordered, in addition to other treatment, an injection of sulphate of zinc, gr. ii., to the ounce of water.

January 11, 1869, patient returned, talking hoarse, and complaining of pains in his bones, to show an eruption which covered his whole trunk and extremities, and which presented, unmistakably, all the characters of a well marked syphilitic roseola. The patient had discovered this eruption by accident a few days before. A most careful and attentive general inspection failed to detect a chancre upon any part of the body, or any hardness along the urethra. Patient denied ever having

had a sore ; genital organs had been affected by no disease before the present one. He had had no bloody discharge nor any localized point of pain on urinating, nor could the most careful palpation discover any induration at any point along the urethra. Here was a case of syphilis which certainly seemed to have a gonorrhœa for its initial lesion. Separation of the lips of the meatus disclosed no ulceration. The gleet discharge still continued ; inguinal glands enlarged, indolent, indurated.

On introducing the tube of Desormeaux's endoscope about six inches down the urethra, the membrane was found to have lost its polish in some measure, and to be of a dusky, dark red. On drawing the tube forward there was distinctly visible along the upper wall of the urethra, about 1 1-4 inches from the meatus, just to the right of the median line, an oval, very slightly depressed, pinkish ulceration, distinctly lighter in color than the rest of the membrane, of about three lines in its greatest diameter, which diameter was parallel with the long axis of the urethra. Dr. Crosby, of New Hampshire, and several medical students who were present, also observed and verified these appearances. Patient was put upon mercury and sulphate of iron, and all treatment against the gleet discontinued.

March 19 he again appeared, stating that he had continued the pills until all his former eruption had left him. His skin had continued clear for a few days, and then another eruption had appeared, for the treatment of which he now presented himself. This eruption was almost exclusively confined to the forearm and leg, and was a syphilide, composed of lenticular papules grouped into circles. Some of the papules were capped by a small pustule. The gleet discharge had long since ceased, and through the tube of the endoscope I saw a pinkish white cicatrix in the place of the old ulcer in the urethra.

Without the endoscope, diagnosis in this case would have been impossible. Urethral chancre situated so deeply that they cannot be seen by separating the meatus are very rare. Bassereau, Clere, Canier, Rollet, Fournier and others report urethral chancres, but in almost every instance the meatus was involved, or the sore could be seen by separating the lips of the meatus. The only considerable number of chancres more

deeply situated are reported by Fournier, who, out of 474 chancres of all parts of the body, found 17 low down in the urethra.

No injection was ever used by this patient except the mild solution of sulphate of zinc above mentioned, nor was any violence ever done to his urethra to cause the little ulceration observed through the endoscope. Rollet states that the induration is always perceptible from the outside in cases of urethral chancre. It was not so in this case, depending, I suppose, upon the fact that the chancre was confined to the upper wall of the urethra, and that the induration could not be distinguished from the hardness of the tough, fibrous sheath of the corpora cavernosa. Moreover, the induration must have been of that parchment-like character often felt under the superficial erosions of external parts, which constitute, sometimes, the initial manifestation of general constitutional infection. I believe that in this case the patient contracted two diseases at the same time—gonorrhœa and syphilis; for, at the end of October, the suspicious contact took place. In a few days a discharge declared itself, which soon became profuse, and which was the cause of his presenting himself to me four weeks afterwards. This disappeared in about two weeks, and the patient thought himself cured; but a more careful subsequent inspection showed him that he still had a slight discharge (differing, however, from the first), and which, probably, had existed with the other, and been concealed by it. How long, then, the period of incubation of this chancre was, it would be impossible to say. Or, possibly, the urethritis may have been caused and kept up solely by the irritation of the chancre. In any case, there was an infecting chancre present, deep in the urethra, and not manifesting itself by any external signs. The endoscope was necessary to diagnosis. Without it the error of considering a urethral discharge as the starting-point of syphilis in this case would have been almost unavoidable.

Reviews.

Das Ekzema Marginatum. Eine Studie über die Natur und das Wesen dieser Krankheit. Von Dr. F. J. PICK, Docenten in der Universität zu Prag. Arch. f. Derm. u. Syph. I. I., p. 61.

(*Eczema Marginatum.* An Investigation into the Nature and Essence of this Disease, &c. F. J. PICK.)

Ueber den Befund von Pilzen bei Ekzema Marginatum. Von Prof. HEBRA, in Wien. Arch. f. Derm. u. Syph. I. II., p. 163.

(*On the Discovery of Parasites in Eczema Marginatum.* HEBRA.)

Zur Verstandigung über das so Genannte Ekzema Marginatum Hebræ. Von F. J. PICK. Arch. f. Derm. u. Syph. I. III., p. 443.

(*For a Clearing-up of the Question about the so-called Eczema Marginatum Hebræ.* F. J. PICK.)

A CONTROVERSY has been carried on for some time past, in Germany, the sum and substance of which is contained in the articles whose headings stand above. The question is one of etiology, and upon its decision rests the rational treatment of the disease the nature of which is contested. The eminent position as authorities in questions of dermatology, which every one must concede to both champions, is a pledge for the interest attaching to the question.

Eczema marginatum is not a common affection, yet it is a very obstinate, and, on that account, a very interesting one, and the discovery of its cause none the less a triumph. The arguments used on both sides seem to be the expression of a thoroughly honest conviction on the part of their authors, and truth is the only proposed goal.

The subject has been already introduced to the English and American public in a general way, and it has been vaguely insinuated that the results arrived at by Köbner and Pick are denied by Hebra. The course of the discussion, as contained

in the three articles of the German Dermatological Journal, leads steadily up to but one conclusion, which conclusion is adverse to the belief and statements of Hebra, to whom the disease *eczema marginatum* owes its description and name. (*Lehrbuch der Hautkrankheiten.*)

In India, this same disease is known as Burmese ring-worm, while Divergie has described it as a herpes. Hebra considered it to be a peculiar kind of eczema, characterized by its constant localization upon the upper and inner part of the thigh, the mons Veneris, and the skin of the buttocks. It commences as a small, round patch, red, elevated and itchy, just where the scrotum lies habitually in contact with the thigh. The eruption spreads circumferentially, healing in the centre as it goes. Instead of one, several patches may spring up and coalesce. The border of the eruption is sharply defined, and forms the distinctive character of the disease. It is composed of papules, vesicles, excoriations and crusts. The surface within the border over which the disease has already passed is left of a brown color, and often has little heaps of dried-up scales here and there upon its surface. Other little patches of disease breaking out into circles in the neighborhood of the original eruption are common. Within this peculiar border new and smaller circles of eruption may spring up, which behave exactly like those which have gone before. Hebra believed the disease to be confined almost exclusively to men, and to be particularly frequent upon shoemakers, their occupation being such as to keep up friction and moisture of the parts, conditions seemingly a *sine qua non* of the eruption.

In first describing the disease, Hebra expressed doubts as to whether or no it were a true eczema, and whether it might not be more justly attributed to syphilis as a cause; but at length, on account of the peculiar characters of the border, he was constrained to class the disease as an eczema.

In 1864, Köbner, of Breslau, endeavored theoretically and experimentally to establish the dependence of the disease upon a vegetable parasite. He discovered the moniliform filaments and the spores of the trichophyton of Malmston among the scales taken from the eruption. He inoculated himself upon the arm with some of this material, and produced several well-marked rings of herpes tonsurans, in the scales of which the microscope again detected the characteristic appearances of the same parasite.

In reply to Köbner's article, which appeared in *Virchow's Archiv*, in 1864, Hebra responded that Köbner was mistaken; that the disease about which he had written was not

an eczema marginatum, but a herpes tonsurans, of which Bärensprung had described many cases and he himself several. He stated further that there was never any vegetable parasite to be found either in the beginning nor during any stage of the true eczema marginatum.

At this point Pick entered the field. In studying the description which Hebra had given to the disease, he believed that he could apply it as a description more justly to herpes tonsurans vesiculosus than to eczema, and he determined forthwith to investigate the subject.

Five cases of the disease are reported by Pick, two of which were typical, and most of which were pronounced to be cases of eczema marginatum by Hebra himself. One other case of the occurrence of the disease, under the breasts of a large, fat woman, is also mentioned. This latter, however, could not, under Hebra's original description, be strictly considered as an eczema marginatum. In every one of these cases the trichophyton was discovered.

Pick also studied the disease in the axilla, where he states it to be not uncommon. Nothing now seemed to remain but to reproduce the disease by inoculation. This was accordingly performed by Pick upon himself, by taking some of the scaly *d bris* scraped from one of the six cases above mentioned, and binding it upon his own person between the thigh and scrotum, in contact with both. The trial proved successful, and the disease commenced to develop regularly. The microscope confirmed the diagnosis. The affection was allowed to progress for a few weeks, and was then removed by treatment. Two months later, Pick, attracted by a slight itching, found, on examination, three little circles of well-marked herpes tonsurans circinnatus on the mons Veneris of the other side from that on which the inoculated disease had developed. The trichophyton was detected by microscopic examination, but the disease was allowed to remain and spread until a new outbreak of papules and vesicles appeared, and then, after the microscope had again demonstrated the parasite, treatment was resorted to.

Led by these researches and experiments, Pick found himself forced to the following conclusions:

That eczema marginatum Hebræ is a parasitical affection, presenting the characters of herpes tonsurans vesiculosus, combined with those of intertrigo.

That herpes tonsurans vesiculosus occurring upon those parts of the body where two cutaneous surfaces are not in almost constant contact, cannot offer the characteristic appear-

ances of *eczema marginatum*, nor can *eczema intertrigo* offer them without the presence of a parasite.

That the disease usually occurs where the scrotum rests in habitual contact with the thigh, because the necessary conditions are most constantly present there.

That, under these necessary conditions, it may appear anywhere, as in the axilla or under the breast in women.

That the trichophyton engrafted upon a previously healthy skin may, under the necessary conditions, give rise to all the appearances of the disease, or the intertrigo may exist first, the parasite taking root upon it, which is what probably most generally takes place, since inoculation of the vegetable parasites takes by so much the more certainly as the epidermis is prepared beforehand by maceration.

That the disease is a compound one, produced by the parasite, the temperature of the part, the moisture, the friction, and the irritation produced by scratching.

As to diagnosis between this and other affections of the part—in *eczema intertrigo*, there is no characteristic border, and the eruption is progressively more severe toward the centre. *Psoriasis* may present a border, but the skin is thickened, and there are no papules nor vesicles. Syphilitic affections of the part do not itch.

There is, however, another affection which might be confounded with *eczema marginatum*. It is of a parasitic nature, and affects the same region, being limited to the parts covered by the scrotum. The skin is of a yellowish red; there exists a well-defined curved border; there are sometimes islands of healthy skin within the border or disks of a similar eruption in the neighborhood, but it differs from *eczema marginatum* in that the color is a yellowish and not a brown red; there are no little heaps of epithelial desquamation on the affected surface. The border, though well defined, is neither papular nor vesicular, the itching is slight, and the disease tends to remain stationary. This disease, according to Pick, is *herpes tonsurans maculosus*, and bears the same relation to the so-called *eczema marginatum* that *herpes tonsurans maculosus* does to *herpes tonsurans vesiculosus* of the rest of the body.

In *eczema marginatum* it is often impossible to detect the parasite upon some portions of the affected surface. To be successful in the search, some of the desquamative debris near the border should be selected for examination.

The treatment consists, first, in emollient, then in parasiticide lotions.

In reply to these investigations and conclusions of Pick,

Hebra yields the point about the existence of a parasite, stating that it is "very often, perhaps always," present; but he does not consider it proved whether this parasite is an exciting cause or only an existing coincidence.

Hebra's argument against the former assumption is as follows: He states that he has long been familiar with a parasitic affection of the parts in question, characterized by a dark brownish-red pigmentation, and accompanied by itching. He considered this a pityriasis versicolor, and was always able to find spores among the epithelial scales scraped from the affected surface. If now, says Hebra, an eczema should occur on such a person upon the same locality as that occupied by the parasitic disease, naturally, spores could always be found mixed with the secretions of the disease. Or, on the other hand, an eczema may first occur and the parasite subsequently take root upon it, as, says Hebra, took place in one of Pick's cases, where, at one time, no parasite could be found, but where it was afterwards discovered in abundance.

His objections to considering herpes tonsurans and eczema marginatum as identical are arranged by Hebra under three heads, and answered by Pick seriatim. They are as follows:

First Objection. Hebra.—Herpes tonsurans always runs an acute course on parts not covered with hair, ending in about two months, with no tendency to relapse. Eczema marginatum, on the other hand, is peculiarly obstinate, and, even when apparently cured, tends again and again to relapse. Thus, for example, one of Pick's cases was still suffering from the disease at the date of Hebra's article, three years and a half after the commencement of treatment. No very positive evidences of eczema marginatum were present, but still the surface was reddened and the parasite microscopically demonstrated.

Hebra cites another case of his own, also treated by Zeissl, where, in spite of all efforts, an eczema marginatum had lasted for years, kept up by constant relapses.

Pick replies that the peculiarities of position cause the difference between the course of the disease here and what it is elsewhere. A herpes tonsurans upon a bald head, and another upon the upper and inner part of the thigh, if the legs could be kept apart and no contact between two cutaneous surfaces allowed, would indeed resemble each other, and would be indistinguishable from a herpes tonsurans of the hairless breast or skin of the abdomen; but now suppose hair to grow upon the head, and the affected part of the thigh to be kept constantly covered by the scrotum, and the one disease would become herpes tonsurans capillitii, the other eczema marginatum,

and the course of the affections would be rendered by so much the more chronic as the relations favorable to the development of the parasite existed more fully, and a relapse would be by just so much the more probable. Pick believes that if the peculiarities imprinted by position upon the disease in the one case demand for it a new name, the same should hold good for the other (*herpes tonsurans capillitii*).

Second Objection. Hebra.—*Herpes tonsurans* breaks out nearly always in many efflorescences, which extend quite quickly, while *eczema marginatum* only very seldom appears multiple, usually remaining where it sprung up, and extending from thence peripherally, a propagation *per contiguum*.

But this point Pick does not consider of importance, inasmuch as Prof. Hebra at first localized *eczema marginatum* upon the thigh alone, but now extends its possible occurrence to the flexures of the joints in general. Pick has seen it in the axilla and under the breast, but there are certainly few portions of the body where the conditions necessary to its existence are present, and this accounts for the infrequent multiple appearance of the disease. *Herpes tonsurans capillitii* presents an analogous example, in that it also is seldom multiple—that is, occurring at the same time both upon the head and pubes. But if *eczema marginatum* be considered as a *herpes tonsurans*, with a local intertrigo superadded, then it is often multiple, as three out of Pick's six cases show, in which, at the same time with the *eczema marginatum*, numerous outbreaks of *herpes tonsurans* occurred upon different portions of the body.

Third Objection. Hebra.—*Herpes tonsurans* attacks the scalp, face and skin of the trunk, while *eczema marginatum* selects the skin in the bend of the joints, particularly the upper and inner part of the thigh, where the skin has been macerated by the collection of a secretion, and irritated thereby. But this maceration is favorable to the development of a parasite, as Hebra proved by experiment years ago, where, by keeping the skin constantly covered with moist compresses, which had not been washed clean, he produced sometimes an *eczema*—sometimes, however, a *herpes tonsurans*—extending peripherally, and presenting appearances very like those of *eczema marginatum*. Here spores must have been contained in the cloths and have been transplanted from them upon the skin.

Hebra finally concludes that if it be right to call an inflammation of the hair bulbs produced by a parasite *sycosis parasitica*, he has still the right to retain the name *eczema marginatum* for this disease, even if a parasite is always, or for the

most part, present upon it, granting for the sake of greater accuracy, the addition of the word *parasitarium*—*eczema marginatum parasitarium*—to those cases where the microscope proves the presence of the *trichophyton*.

To this Pick rejoins that the disease may indeed occur where the skin is irritated by being macerated in its own secretions, but this condition only exists where two cutaneous surfaces are in very frequent contact. Yet even here, under ordinary circumstances, an *eczema marginatum* does not result, but an *intertrigo*. What, then, is the main and peculiar point of difference as to physical characters between *eczema marginatum* and *intertrigo*? Assuredly, the striking appearance of the border. Without this border every *eczema marginatum* would be called *intertrigo* by all dermatologists. But the border presents the characteristic appearances of *herpes tonsurans vesiculosus*; consequently, the only possible conclusion is, that *eczema marginatum* is a combination of *intertrigo* with *herpes tonsurans vesiculosus*. The disease produced by Hebra by macerating the skin with soiled cloths is, for Pick, in very fact, an *eczema marginatum*.

Regarding the existence of a parasite in the disease, there can be no doubt, since even Hebra admits its presence "very often, perhaps always." Inoculation with the material taken from the affected surface has produced *herpes tonsurans* on the person of Köbner, and the same gave rise to *eczema marginatum* when properly applied upon the person of Pick. Maceration of the skin with soiled cloths containing a parasite, produced for Hebra a disease "very like *eczema marginatum*." In the early stages of the disease, Pick and Köbner always found the *trichophyton*. It was only after treatment, or where spontaneous involution of the *herpes* had taken place, that the parasite was absent; but if now the disease was left to itself, a full development of the border again appeared, and the parasite could again be found. Moreover, even if the parasite occasionally could not be detected during the full development of the disease, it would not be of the greatest importance, since the same occasionally occurs with true *herpes tonsurans* of the hairless skin. The *intertrigo* may continue after the parasite has been destroyed, and yet a relapse occur by a new crop of spores taking root upon the spot already favorably prepared for them, as occurred in one of Pick's cases noticed by Hebra.

Finally, the disease is either caused by the parasite, or it is not. In the first case, the name *eczema marginatum* is wrong; in the second, the addition of the word *parasitarium* is superfluous. Pick believes that, for clearness and correctness, the

name *eczema marginatum* should be changed, and courteously leaves it for Hebra to decide whether more harm than good will come to the nomenclature by its retention.

What special summing up is necessary? A parasite is found in the disease; occasionally it cannot be demonstrated, but now, leaving the malady a few days to itself will afford an abundance of specimens. The parasite is the trichophyton of Malmston. Inoculation from *eczema marginatum* will produce ordinary herpes tonsurans of the hairless parts, and *vice versa*, as the second and accidental part of Pick's inoculation showed. Is, then, the disease parasitic and identical with herpes tonsurans, or not?

The courtesy shown on both sides in the discussions, lends to the subject an unusual charm, and calls for recognition and approval; for, while it smoothes down the asperities of differences of opinion, it renders the discussion more interesting, and materially enhances its value, in that it stamps the controversy as a serious search for truth, and not a personal dispute between two men in high position, but of different views. If more of this spirit could be thrown into discussions in general, we should have, in truth, less words, but our conclusions would be by far more correct. Out of the present discussion the results arrived at are valuable and of practical importance in suggesting the proper treatment, and they are equally valuable whether or not the disease still continues to receive the name bestowed upon it by Hebra.

E. L. KEYES.

Atlas of Venereal Diseases. By M. A. CULLERIER, Surgeon to the Hôpital du Midi, etc. Translated from the French, with notes and additions, by FREEMAN J. BUMSTEAD, M. D., Professor of Venereal Diseases in the College of Physicians and Surgeons, New York, etc. Philadelphia: Henry C. Lea. 1868.

THE French edition of Cullerier's "Atlas of Venereal Diseases," with its beautifully-colored plates, is well enough known to French readers; for introducing it, in a pleasing dress, to those who are unable to read or obtain the original, Dr. Bumstead deserves the thanks of the profession. Any one conversant with this treatise on venereal diseases, which at once raised him to the front rank of syphilographers, would have expected from his pen, in the way of translation, only one of the very highest order. Such a one he has given us—enriched, moreover, with notes which add materially to the value of the work. As a duallist, he has frequent occasion to

differ with his author, but invariably with the utmost fairness and courtesy.

Great credit is due to the publishers for the elegant make-up of the book. It was first published in parts, the size of the pages having been enlarged to a *quarto*, each plate including four of the original; but it may now be obtained in a single bound volume. The plates are fine specimens of chromolithography, scarcely inferior to the original. The print is excellent, and altogether the volume is well worthy of perusal by all interested in syphilography.

Selections from Foreign Journals.

ON THE USE OF ICE IN CERTAIN AFFECTIONS OF THE TESTICULAR APPARATUS.

BY P. DIDAY.

(From the *Annales de Dermatologie et de Syphiligraphie*.)

TRANSLATED AND ADAPTED WITH NOTES BY THE EDITOR.

IN presenting, in an English dress, M. Diday's contribution to the therapeutics of testicular affections, we have endeavored to give a tolerably full and literal translation of the article, omitting what would be regarded by many readers as prolixities, some of which were not only irrelevant, but marred an otherwise very valuable contribution.

The author begins by claiming for his revival of the use of ice in the treatment of testicular affections "all the usefulness, if not all the merit, of a true discovery." He then proceeds to say that the use of ice has been of service with him ; first, in the orchitis which sometimes complicates blennorrhagic epididymitis ; secondly, in testicular neuralgia (irritable testis) ; thirdly, in certain other complex conditions, the nature of which is undecided, but of which the item of *pain* constitutes the prevailing character.

I. BLENNORRHAGIC ORCHITIS. As epididymitis does not co-exist with every urethral blennorrhagia, so orchitis does not accompany every epididymitis. When *the clap falls into the bag*,¹ as the vulgar expression has it, the epididymis alone is ordinarily involved, and the testicle shares in the inflammatory engorgement only in exceptional cases. This is a fact of which there is no longer any doubt since the very precise data which Ricord had the merit of substituting for the vague and confined notions of the old syphilography in regard to the lesions constituting the engorgement of the testicles which supervenes during blennorrhagia.

¹ *La chaudpisse tombe dans les bourses.*

When the testicle in its turn becomes involved, matters proceed in the most regular manner. The patient—having suffered for three or four days from epididymitis, an affection very painful of itself—gradually feels his suffering increase to an extreme degree. He experiences in the testicles a sort of agonizing tension, comparable, for intensity, to the most excruciating attacks of otitis, or of dental neuralgia. This pain, which reaches its maximum of violence in a few hours, does not remain limited to the gland; it extends along the cord to the inguinal ring, and mounts from there even to the iliac fossa, the flank and the loins. At once continuous and intermittent, it has, without ever completely ceasing, terrible exacerbations. Under such circumstances you see the patient sweating, his face flushed, tossing upon the bed and unable to maintain the prescribed repose, obstinately refusing local remedies, so much does he dread the touch of anything upon the organ; the prey to a condition which partakes of both the dejection and the nervous excitement which the incessant exacerbations of local pain awaken. At the end of twenty-four hours, nausea and a saburral condition ordinarily accompany this inflammation, and febrile reaction is no longer wanting.

What is to be done for this suffering? Narcotics scarcely palliate it. Emollients (poultices, baths) are as powerless as they are impracticable. Leeches give a few hours' calm; but, usually, at the time when the orchitis shows itself, they have already been employed for the preceding epididymitis. Repose is impossible. Compression—it is out of the question.

The cause of the pain being the strangulation of the testicular parenchyma in its tunica albuginea, it will be understood that the incising of this inextensible envelope answers the indication better than any other remedy. However appalling may be the proceeding, the patient not only submits to, but demands it, when he is assured that it is the only means of assuaging his sufferings. And, indeed, composure soon follows the stroke of the bistoury.

But because the patient accepts the procedure, does it follow, in the view of the physician, that the operation is indicated? Certainly not, if it be shown that there are grave inconveniences inherent in it. There is to be feared, in consequence of it, an accident which I have twice observed, and the contemplation of which is enough to make me absolutely reject it; I refer to atrophy, or, rather, consecutive *diminution* of the testicle. Let me explain:

I had already seen, in a patient formerly operated on, since under the treatment of one of our most skillful specialists, this

diminution of the testicle, following incision of the albuginea, done for a blennorrhagic orchitis.¹

But I could not avoid the thought that "He had overlooked the warning of J. L. Petit concerning the exposure of the semiferous ducts, which so easily takes place when the dressing of wounds of this sort is done without the necessary precautions"

A second case soon happened to myself. In September, 1846, having had to treat one of my friends for a blennorrhagic orchitis, I could not, after three applications of leeches, put an end to the frightful pain except by incising the testicle, according to the method of Vidal (de Cassis). At first everything went well; the sedative effect was instantaneous and lasting. But not so in the subsequent progress. Yet I was prepared. I knew with what care it was necessary to attend to the healing (*laisser guérir*) of the incision. I touched it as little as possible, and I kept it from being touched. There was no dragging, scarcely any contact exercised on the exposed seminal canals, and yet, at the end of a month, in consequence of partial mortification and successive sloughing, which I saw going on without my being able to check it, the testicle had diminished by more than half.

At the end of about a year this same patient contracted a fresh blennorrhagia, which, as usual with him,² was accompanied by epididymitis, which also was complicated with orchitis. In view of the extreme pain which he experienced, the certain aggravation of which he foresaw, not willing either to endure it or to undergo the incision, he begged me to seek some other means.

It was then that the persistent use of ice on the affected organ presented itself to my mind. It succeeded beyond my most sanguine expectations; and, since then, applied under the same conditions, I affirm that it has always, without a single exception, succeeded. Need I add that I no longer resort to any other medication?

Here are two cases, among many examples that I might cite,

¹ Probably very many of our readers have seen instances of wasting of the testicle, following epididymitis, where incision of the albuginea had not been practised.—ED.]

² Certain patients have, with each blennorrhagia, an epididymitis, or a cystitis, or joint inflammations. With them it is so much the effect of a special individual predisposition, that the same series of accidents is reproduced with each clap, mild or severe, and in spite of every care, of every supposed preventive precaution.

all equally convincing, in which the efficacy of cold was manifested in a particularly striking manner :

A young Russian officer, just arrived at Lyons, had had blennorrhagia a month, but he thought lightly of it, having in his pocket detailed directions which, he said, would preserve him from all accident, and guide him, without complications, to an early cure. In short, nothing could be better digested, more minutely precognizant, than that page signed with a Parisian name which had no need of praise.

An epididymitis having, nevertheless, supervened, there showed itself, in spite of repose scrupulously observed, leeches in good number applied to the cord, opiated poultices, mild laxatives—there showed itself, I say, the special painfulness which characterizes blennorrhagic orchitis. Our man was not prepared for this event, so he had to call in the aid of Lyons medicine. One of my most skillful colleagues, called to attend him, applied a dozen fresh leeches, covered the scrotum and the cord with various narcotics, also administered internal remedies, all the while maintaining a free state of the bowels with enemata.

Twenty-four hours passed thus, and the pain not only remained, but kept increasing. More leeches were applied, an attempt was made to try compression, an emeto-cathartic was given, with the praiseworthy object of clearing out the *primæ viæ*. Nothing was accomplished, and when, sent for in my turn, I came the following day, this young man presented a very sad spectacle. Enfeebled by seventy-two hours of suffering and sleeplessness, by loss of blood and low diet, he lay, half narcotized, without any diminution of the testicular pangs, which, in spite of his depression, continued to recur regularly.

Ice was prescribed. At the end of four hours, the young man, able to continue his journey, went south to recover from the effects of the malady, as well as from those of the treatment.

About twelve years ago, a trader of a neighboring city, having contracted a blennorrhagia, came to Lyons to be treated. An epididymitis showed itself, and he was confined to bed in a *maison de santé*. For several days he had very regularly followed out the usual treatment—leeches to the cord, poultices, diluents. He strictly maintained repose, even immobility, when, on the fifth day from the accident,¹ towards noon,

¹ These *fifth-day exacerbations*, which consist in a return of the epididymitis or in the invasion of orchitis, for which no imprudence can account, are one of the most ordinary characters of "the clap fallen into the bag." I explain them by the same cause which makes rheumatism,

he sent for me in great haste. I could not reach him until after two hours, and already he was twisting, groaning on his bed, a prey to pains which, he kept saying, would, if they continued, set him crazy.

[Fournier regards blennorrhagia as the essential, efficient, indispensable cause of the rheumatic accidents, the totality of which constitutes what is called blennorrhagic rheumatism; that it is which determines them, and which of itself alone is sufficient to produce them, independently of the concurrence of any other appreciable provocation. Conversely, these accidents never manifest themselves apart from blennorrhagia; under its proper form and with its proper symptoms, the affection called blennorrhagic or urethral rheumatism never manifests itself except with a blennorrhagia.—ED.]

I recognized, without difficulty, the cause of his sufferings in the commencing development of an orchitis, and I no more hesitated about the indication than about the etiology.

[M. Diday had arranged to go on a short journey, which he felt obliged to begin without delay; but his confidence in the ice treatment was such that he felt no hesitation in ordering it and in assuring the patient of its speedily putting an end to his suffering.]

I gave the most minute instructions in regard to the use of the refrigerant agent, promised the patient immediate relief, and accomplished my journey without anxiety. [On the next day he found his expectations realized.]

RULES OF APPLICATION. Should my description appear excessively minute, I claim the greatest latitude; for I wish every practitioner, after having read it, to be able to draw from this therapeutic resource the same benefit as myself. Above all, I am desirous that they should not, for want of ample illustration, run the risk of a deception which would be as annoying to me as to them.

Materials.—Two hogs' bladders, to be soaked a few minutes in order to soften them and make them pliant. Introduce into them through the opening, enlarged by a stroke of the scissors, four or five pieces of ice as large as a goose's egg. Before tying the neck of the bladder the air should be carefully expelled from it, which is done by pinching it together between two fingers above the ice, and compressing it from the fundus to the opening. Without this precaution, the bladder, remaining inflated with air, would form a sort of incompressible balloon,

after a few days of calm, invade a fresh joint. In this comparison there is more than one analogy; for there is identity of nature between epididymitis and blennorrhagic rheumatism.

difficult to apply, and incapable of being folded so as to be applied to the parts which it should *envelope* rather than merely *cover*. It is in order the more easily to accomplish this latter end that I recommend, also, the tying of the bladder as near its opening as possible, in order to leave more size, more looseness, after the manner of a soft hat, which it should look like on being applied to the testicle.¹

Application.—The patient lying on his back, one of the bladders, thus prepared, is to be placed under the scrotum, the thighs and perineum being protected with napkins, so as not to needlessly subject these parts to the impression of the cold. As regards the other, place it over the scrotum, in such manner that, in case of need, it can be extended over the cord as far as the inguinal ring. To maintain it neatly in its place, I make a handkerchief or a small towel into the shape of a ring. Thus adjusted in the middle of this ring, which may be left larger or smaller, the bladder rests there of its own weight, without the patient having to look after it.

Effects.—Usually the first impression is agreeable. Sometimes, however, in case of extreme sensibility, there is an instant of pain at the moment of application; but this pain is not caused by the cold, but by the weight of the ice. This may be asserted, first, because the *lower* bladder never produces this suffering; in the second place, because it can be relieved by holding the *upper* bladder suspended for a few moments, instead of leaving it to gravitation. At any rate, in most cases immediately, in exceptional cases at the end of five minutes, the patient gets accustomed to the new sensation. A quarter of an hour does not pass without his being aware of a commencement of amelioration. This calm succeeding the preceding torture causes a grateful feeling. *At the end of an hour*, as a general rule, the testicle has perceptibly, although very slightly, diminished in volume, and there is no longer any pain. As a no less general rule, the pain does not return, if the use of the ice is not too soon left off.

Duration of the Application.—The ice should remain on constantly for at least eighteen hours. This lapse of time is sometimes sufficient, especially when the ice has been applied just at the commencement of the special painful state. But, in general, a longer time is necessary. Forty-eight consecutive hours seem to me the average length of time which best accords with what my own experience has taught me. To ascer-

¹ It will be found advisable to insert a cork in the opening of the bladder to afford a purchase for the twine—adding additional security against the escape of the melted ice.—[ED.]

tain when the treatment can be prudently suspended, raise the bladder, and with the end of the finger press on that portion of the testicle which, during the pain, was the most sensitive. If it is still painful under the touch, the ice must be continued longer. Should you remove it now, the renewal of the pain, at the end of a few hours, would oblige you to renew its application; and, during the interval, the disease would have taken on increased strength.

I remember many cases in which it has been necessary to continue the cold a much longer time, even two, three, and, indeed, five consecutive days. In this respect two categories may be established. In some of these patients it was at the outset, without being guided by the effect of tentative intermissions, that the refrigeration was thus prolonged. And I was made aware of this necessity by a certain continuance of the pain which, in spite of the continued use of the bladders, persisted, without being really severe, to the degree of dull pain, a sure omen of the return of the suffering on ceasing the use of the sedative measure. The patients are not deceived in this matter, and they do not let the physician deceive himself. In others, the suffering begins again one or two hours after the ice is removed; the testicle speedily becomes again sensitive to the touch at one point; and, after several fruitless trials, it is necessary, to prevent all relapse, to decide on an uninterrupted application of twenty-four, thirty-six, or forty-eight hours.

It is to be remarked that, in cases where it is necessary, this long duration does not weary the patients. A particular sensation apprises them that the subjugated enemy still threatens; they prefer, and very decidedly, subjection to constraint rather than the anguish they have just undergone, and are the first to entreat to be kept under the influence of the remedy.

Immediate and Consecutive Measures.—It is needless to remark that the ice must be removed as soon as it is nearly melted. But on patients and their nurses it is necessary to impress it, to show that every danger, if the mere application contents them, continues. Especially at night a watchful attendance must be established, and assurance made that the stock of ice does not fail. As a rule, when the bladders have been properly filled, the ice need be renewed only every second hour, a sufficient time for the patient to get asleep.

When it is judged convenient to stop the ice—whether temporarily or once for all—it is important to keep up for about an hour the application of cold wet cloths to the testicle. Thus a gradation is effected between the artificial refrigeration the organ has undergone, and its return to the nor-

mal temperature, a precaution the importance of which should be impressed on the patients by reminding them of the sensation of heat, and of the inflammation which is thus shown to have taken place, when one withdraws one's fingers from the snow after having held them there for some minutes.

Accidents.—I am unable to perceive any worthy of the name. Almost always nurses apprehend a catarrh, a depression, in consequence of the cold application; experience has never realized their fears.

Gangrene, also, is mentioned as liable to result from the action of the cold on *so fine* a skin, and on *so sensitive an organ*! I have never seen anything like it, nor anything approaching it. A rather common accident consists in a temporary neuralgia of one of the branches of the crural nerve, towards the outer side of the thigh. But it may be avoided, if care is taken, as I have pointed out, by withdrawing the nerve itself from the direct action of the ice, by keeping a towel between the bladder of ice and the thigh.

II. NEURALGIA.—Neuralgia, in the testicular apparatus, displays its ordinary variable and erratic characters.

In spite of this extreme variability, there none the less exists a typical condition, which has received a distinct name (irritable testis), of a uniform physiognomy, of constant attributes. It is characterized by the absence of structural lesion in the testicle or its appendages; often by absence of antecedent disease in this apparatus; by pains, bearable as to their intensity, but peculiarly annoying by their continuousness; by the constancy with which certain conditions modify these pains—dorsal decubitus, or mental distraction rendering them lighter; walking, or crossing the legs aggravating them—and this double effect being always produced, in all subjects, without being modified by repetition. The nearer a testicular neuralgia approaches this stage, the surer I am of curing it by the application of ice.

[Here two cases are cited.] A watchmaker, 22 years old, of good constitution, although somewhat spare, who had formerly on one occasion indulged moderately in venery, who was free from seminal losses, and without venereal antecedents, had suffered from testicular neuralgia for eighteen months, when he consulted me, in January, 1866. The pain involved the testicle, and especially the epididymis of the right side. It had developed gradually without known cause. As it was alleviated by rest, so it was increased by standing or walking, which fact caused him to change his business of a commercial traveller to one which allowed him to remain sitting.

He could not take a walk of more than half an hour without the pain commencing, and, if he continued, suffering torture. He eloquently, but in the way of pleasantry, characterized himself as *the direct opposite of the Wandering Jew*. On one occasion, having walked on regardless of the neuralgic warnings, the pain extended to the loins, and persisted until the following day, in spite of the night's rest. [This young man had made a study of his malady, was familiar with the standard authorities on the subject, and defied M. Diday to cure him. The challenge was accepted, with the understanding that the patient should conform absolutely to the prescriptions for ninety-six hours. M. Diday himself applied the bladders, in the manner described, taking care to guard against excess of pressure. At the end of four days the treatment was discontinued, our author pronouncing, as he confesses, the *surge et ambula*, not without curiosity mingled with some apprehension. The result, however, was satisfactory. The patient could walk like other persons, even without a suspensory. He still felt a sensation of weight whenever he had walked six or eight kilomètres. But the night's rest wholly dissipated it, and he passed whole months without feeling the least annoyance from it. It is added that he either did not wish, or did not dare to quit his sedentary occupation.

The second example had been previously published in a provincial journal,¹ and is here reproduced entire:]

M. X., a physician, aged 25 years, of lymphatico-sanguine temperament, contracted syphilis fifteen months since. He experienced only a few very light results, lasting two months, after which, for about a year, there was no syphilitic manifestation.

In the month of September last, X. fell ill, and was attacked with ill-defined symptoms, constituting a partially developed catarrhal fever; a saburral condition of the digestive passages, diarrhoea, intense headache, neuralgic points in different quarters of the body, principally on the right side of the chest, where a blister was applied. X. had kept his bed for twelve days; there was great amelioration in the general symptoms, when one morning he felt a somewhat severe pain in the left testicle; there was noticed a slight swelling of the epididymis, a swelling which also affected the gland itself. Poultices, hip-baths, and frictions with ointment of iodide of potassium were prescribed.

The following day the testicle and epididymis of the right side participated, but to a less degree than those of the left; the vertical position was become impossible; the testicles hung at the bottom of the scrotum, which was red, shining, not painful. The spermatic cord, on either side, showed infiltration and sensibility. This sub-inflammatory state of the genital apparatus continued twelve days, at the end of which walking became possible, and the patient left Lyons to go to his family, feeling only a testicular hyperaesthesia, more pronounced on the

¹ Gazette Médicale de Lyon, 1867, p. 130.

left than on the right, but never showing itself when the patient was lying down or seated. X. remained absent fifteen days; his general condition, altered by a three weeks' confinement to bed, was become much better, but the sensitiveness of the testicles remained the same, and at the end of some days changed to a continuous pain, supportable in degree, which X. compared to that of moderate constriction of the testicles. Sleep was not disturbed, but, from the moment of rising to that of going to bed, this vermicular sensation left no comfort to X., whose *morale* finally became so seriously affected as to make him avoid all society.

Yet the volume of the testicles was not increased; there was a scarcely observable engorgement of the left epididymis; no varicocele. Pressure slightly increased the pain, walking moderated it a little, probably by the mental distraction it procured him. Thus he often took long walks, to escape from it. Moreover, he was obliged to do so to avoid yielding to the desire of masturbation which was caused by this constant sensation of a hand lightly compressing the testicles. These were both the seat of pain, but the right one much less than the left.

Cotus increased the trouble, after momentarily assuaging it. At first X. tried several methods of treatment—frictions with iodide of potassium, and with belladonna ointment, but with no result. He decided to consult M. Diday, who, finding no appreciable organic lesion of the testicle, considered the condition simply as one of neuralgia, of which it was necessary to search out the cause.

Bearing in mind the antecedents of the patient, who formerly had suffered from rheumatoid pains in the side, in the wrists, and in the ankle-joints, M. Diday at first directed his treatment against a probable syphilitic diathesis. He prescribed applications of chloroform along the tendons, mercurial frictions every second day, and iodide of potassium. The patient scrupulously followed this treatment for fifteen days; he received no benefit from it. M. Diday then suspended the anti-syphilitic treatment, substituting iron and the preparations of cinchona, thinking that the neuralgic pains were perhaps connected with an anæmic condition. There was the same negative result at the end of three weeks.

X. became more and more downcast, seeing his condition persist. M. Diday then ordered him the following treatment: To apply for forty-eight hours, above and below the testicles, bladders filled with ice, renewed as fast as it melted.

This treatment produced, the third day, a notable amelioration. X. was obliged to set out the fourth day for the South. He travelled on foot, short distances each day. He was scarcely three days from Lyons, when the pain entirely disappeared, although the testicles were still sensitive to pressure. During his journey, which lasted seventeen days, X. did not once experience painful sensations in the testicles. Since this journey, X., who has returned to Lyons, is almost quit of his testicular neuralgia. At times he still feels a few insignificant painful sensations.

These two examples of the power of ice over testicular neuralgia seem to me sufficient. Like success will not always follow—certainly it has not with me. But, I declare it with equal frankness, I have never completely failed. Ice in such cases invariably produces an amelioration—I can justly add, more amelioration than any other remedy, local or constitutional. When it does not cure at once, it very often does if

repeated on several occasions *pro re nata*. In the least favorable cases, if it is powerless to cure, it is at least an efficient palliative.

[Our author then cites the additional case of a man whose business interfered with a due observance of the treatment for a sufficient period to effect a cure, but in whom twelve hours of the ice treatment regularly procured six weeks of freedom from the pain.]

VARIOUS MORBID CONDITIONS. I arrange under this head several morbid conditions, of variable cause and form, affecting different portions of the testicular apparatus, and of which *pain* constitutes the chief character.

The more the symptoms resemble neuralgia, the more amenable is it to the ice treatment. I will first demonstrate that what is inflammation and not neuralgia eludes the power of ice. I have only to cite the example of blennorrhagic epididymitis, the most frequent, and assuredly the best characterized of the acute inflammations of the testicular apparatus. This, the only phlegmasia for which I now order leeches, is not at all influenced by ice. The following case will of itself establish the fact:

I had, in July, 1858, cured a friend of a left blennorrhagic epididymitis, which, being complicated with orchitis, had produced those severe sufferings of which I spoke in the first part of this paper, and which nothing but the prolonged use of ice could stop. But scarcely was the orchitis cured when the right epididymis became involved in its turn (*epididymite à bascule*, of Ricord). Ice, which had rendered us such service, at once suggested itself to both the patient and myself. So, at the very commencement of the sense of weight which announced that the right epididymis was going to be involved, my patient betook himself to bed with his two bladders of ice fixed *in loco dolente*. For two days we thought ourselves successful, for the organ swelled only a very little, and the pain scarcely deserved the name. But on the third day, without the treatment having been interrupted, without any imprudence committed, the affection took on its ordinary course, and the engorgement and sensibility of the organ became such that it was necessary to leave off the ice, and to apply leeches over the cord. From that time the epididymitis progressed with its ordinary phases and its ordinary duration, without the ulterior complication of orchitis.

In inflammation of the testicle, also, it is as powerless against the element of *phlegmasia*; and, if in this inflammation it is of so great service, if it appears to be a specific against it, it is because, although engendered by inflammation, the element of pain plays the leading part; because, moreover, it is so violent that to cure it may justly be reputed curing the disease itself.

So, it is against *pain* that the use of ice is effective; and to this it ought to be restricted. But the causes capable of pro-

ducing this pain are numerous and diverse. Here are the principal varieties, such as I can remember them from my practice.

The kind most frequently observed is that which follows blennorrhagic epididymitis, and is most frequently met with among the subjects of varicocele. Its ordinary seat is on the left side. It is anything but a neuralgia, properly so called. Its crises are not separated by intervals, and do not return without exciting causes; neither do they cause that intense suffering peculiar to neuralgia. In short, the series of crises, considered as a whole, does not increase and then diminish, as observed in sciatica or facial neuralgia. On the contrary, the epididymic pain, should it last five years, would rekindle itself every day with the same intensity under the operation of the same exciting causes, namely, walking and standing; moderating regularly each night, during dorsal decubitus. The slightest causes, the lightest local injuries, a catheterism, a certain position, may, in subjects thus predisposed, awaken the neuralgic susceptibility. [The author then gives two instances in which it followed puncture of cysts of the cord.]

ON THE USE OF CAOUTCHOUC IN THE TREATMENT OF SKIN DISEASES.

BY PROF. HEBRA, OF VIENNA.

(From *Archiv für Dermatologie und Syphilis*, 1869.)

TRANSLATED BY DR. FOSTER SWIFT.

ON my last visit to Paris, in Sept., 1867, Prof. Hardy said to me that he frequently availed himself of vulcanized India-rubber cloth in the treatment of eczema with good effect, and that he applied this pure and simple on the diseased parts. At that time there was no suitable case at Hardy's clinic, so the use of the India-rubber cloth could not be shown. I had to be satisfied with the suggestion, and institute independent observations on my return home. This I did throughout the whole year, and I beg leave now to communicate the results attained by this mode of treatment. *A priori* it was to be expected from the use of India-rubber cloth that, from its known impermeability to watery fluids, the evaporation of the fluid secretions would be interfered with, and a collection of the

fluid between the skin and the India-rubber cloth was to be expected. Now, this fluid, consisting of the normal secretions of the skin, being long in contact with, reacts upon the epidermis, softening and macerating it, so that the same effects would be produced as through protracted soaking. It was just as if the skin were immersed in a continued warm bath of its own secretions, applied to the diseased part, and naturally the same therapeutic results would be obtained as from protracted baths.

This supposition has been only in part realized, and especially if the pure and not the vulcanized India-rubber is used. In the latter, the material used in vulcanizing must be taken into account, particularly the sulphur, so that an envelopment in vulcanized India-rubber cloth—in order to carry out the above comparison—is like a continued warm sulphur bath. In instituting this comparison, it should not be forgotten that the normal fluid skin-secretions, sweat and sebaceous matter, are entirely unlike common water, in the fact of their containing acids and salts, and especially fatty materials, developing fatty acids by their rapid decomposition. By the protracted application to the skin of such a compound, a different effect would be induced than by the use of either sulphur or ordinary water; and, moreover, the substances used in the manufacture of India-rubber cloth should not be disregarded. From these facts, and also from the knowledge that very frequently a variety of eruptions are caused by the action of the various secretions of the skin, I could not form an unconditionally favorable prognosis from the use of India-rubber in the treatment of skin diseases. But, on the other hand, it is known that the very means which under certain circumstances will produce eczema, under still others is capable of relieving it; so, giving up rash criticism, I awaited the result of careful experiment. How far my opinion was justified by the result, will appear. But before mentioning in detail the cases of skin disease treated with India-rubber, let me describe the materials used in its manufacture. The vulcanized India-rubber cloth used by Hardy consists of common cotton cloth, which is plastered over with a solution of India-rubber, and then subjected to a process called "vulcanization." This consists in powdering the cloth over with a mixture of India-rubber and sulphur, and then submitting it, under pressure, to a high temperature. The cloth treated in this manner acquires a gray color, a thick texture, opaque and impermeable for watery fluids; on one side it is smooth and shiny, and on the other uneven. It smells of sulphur and India-rubber. Oil, as well

as every kind of fat, and alcohol dissolves the layer of India-rubber, destroying its desirable peculiarities. It can be worked like any other cotton cloth—that is, it can be cut and sewed, and even pasted layer upon layer, for which last purpose a peculiarly prepared glue containing India-rubber is requisite. These peculiarities of India-rubber cloth led me not only to apply it simply on the diseased places, as Hardy advised, but I had manufactured various articles of clothing—caps for the head, sacs for wrapping particular regions of the body, gloves, stockings, and, finally, breeches, with or without coverings for the feet attached, as well as shirts and blouses. Besides these articles made of vulcanized India-rubber cloth, I have the plain India-rubber made up into gloves and bandages, and am convinced of their use. I have not confined myself, in the use of this agent, to the treatment of eczema alone, as Hardy advised, but gradually I experimented on its effects in other forms of skin disease, and especially where I desired to macerate and soften down dry, brittle masses of epidermis, as in psoriasis, ichthyosis, zylosis and pityriasis, and also in the lighter grade of burns, in variola, and in some cases of pruritus in old men. After these general considerations, let me narrate some of the cases treated in this manner, and, in particular, eczema.

We have subjected to this form of treatment every variety of eczema, from the scaly to the pustular form, using either closely-applied pieces of India-rubber cloth, or bandages, or clothing made of that material. In every case the smooth side of the cloth was brought in contact with the skin, the products of the disease—scales, crusts, &c.—either having been first removed, or else, by way of experiment, the cloth sometimes applied directly over these. If the India-rubber cloth be removed after twelve or fourteen hours, it appears very moist—sometimes permeated by moisture—and the fluid which has collected in great quantity on the surface of the skin has a very penetrating and disagreeable odor. The skin itself, however, after having been cleansed from its superimposed collection of softened skin secretions, was odorless, reddened, somewhat deprived of its epithelial covering, moist and shining. While the India-rubber was applied, the patient experienced no disagreeable sensation—neither itching nor pain after removal of the covering; however, itching immediately re-occurs, and if it is not replaced for some time—say half an hour—a sense of tension and pain commences. If the treatment is continued in this way, the whole train of symptoms diminish—moisture, redness, itching and pain—and in many cases the cure of the

eczema will occur at the end of two months. As is well known, a cure of eczema can be effected in the same space of time by various means. The question then arises, what advantage does the caoutchouc treatment offer above any other? The answer is, that if no especial advantage can be recognized in India-rubber, nevertheless there are some cases in which this form of treatment can be more beneficially employed. I refer to cases of eczema of the hands, fingers, large joints, scrotum and feet, in which the application of salves is attended with many inconveniences to the patient. Moreover, the India-rubber preparations are calculated to relieve the pain caused by fissures, because the impermeable covering keeps the part continually moist, which can be done by the application of India-rubber gloves, finger-stalls, bandages closely applied, suspensories and stockings. If, therefore, by the use of caoutchouc in the treatment of eczema, no new panacea has been introduced into the therapeutics of skin disease, yet it must be recognized as a very valuable addition; and so much the more, as it does not forbid the use of any other application. Thus, in many cases, the cure of eczema is materially assisted by the simultaneous use of soap, baths, douches, preparations of tar; and these last are rendered more efficacious by the use of caoutchouc cloth. There are other diseases of the skin, especially the callous thickening of the epidermis, in pityriasis, xerosis, psoriasis palmaris, as well as in zylosis of the sole of the foot, where India-rubber stockings render the painful fissures painless immediately, and their continued application will induce a cure. In some cases of burns of the second degree, the same plan of treatment was attempted, and it succeeded perfectly; but at the same time I could not attribute it to any advantage over cold or lukewarm applications, or the use of the common ointments, lime-water and sweet oil, &c. In order to macerate the epidermic covering of the small-pox eruption, so as to favor the re-absorption of the contents of the pustules, or to promote their discharge, I attempted the application of the India-rubber cloth—that is, I applied India-rubber bags to the extremities, changing them every twenty-four hours, and cleansing the skin. The course of the small-pox, indeed, was not in the least changed by this mode of treatment; only the marked maceration of the thick epidermis on the soles of the feet and palms of the hands decreased essentially the pain so often present in these regions, and this was the only advantage in this form of treatment. India-rubber was most effectual in four cases of general pruritus, which certainly commenced in connection with eczema, but also extended to non-eczematous por-

tions of the body, and could properly be designated as pruritus cutaneous senilis. Four old men between sixty-five and seventy-five years of age were the victims of this disease—one only in hospital, the other three in private practice. In all four patients I had complete suits of the vulcanized cloth made, and made them at the first wear them day and night next to the skin, the garments either to be changed night and morning, or if, as in the case of the hospital patient, only one suit was to be obtained, it should be taken off for a short time, washed, cleansed, and again put on. The effect of treatment showed itself from the first day, in the fact that sweat was secreted more freely, itching and tension of the skin subsided, and sleep returned. The patients were all pleased by the result, and submitted gladly to further treatment. After the expiration of a few weeks the India-rubber clothes were worn either only at night or for a few hours during the day, until, after complete convalescence, they could be removed. The eczema, too, could be so much the more readily treated with the usual applications, tar, &c., as the caoutchouc covering modified the odor and prevented staining.

In conclusion, I must reiterate that the India-rubber treatment can be relied on to obviate the itching and tension; but for the relief of the eczematous inflammation, tar, &c., must be used.

ON THE ANALGESIA OF SECONDARY SYPHILIS.

BY ALFRED FOURNIER.

MÉDECIN DES HÔPITAUX, AGREGÉ À LA FACULTÉ DE PARIS.

(From *Annales de Dermatologie et de Syphiligraphie*.)

TRANSLATED BY DR. FRANK P. FOSTER.

[THE original article being an extract from a clinical lecture at the Lourcine Hospital, its *quasi-colloquial* style rendered some slight alteration of diction expedient; and, in addition, it was thought best to condense some of its non-essentials.]

I show you here a young woman who contracted syphilis three or four months since, and who now presents numerous specific manifestations—a papular syphilide, crusts of the scalp, enlargement of the cervical glands, a certain amount of alopecia, pains in the joints, evening headache, etc. I force

this pin deep into the skin of the right hand, and she shows no pain. I pierce here and there the skin of the other hand, still no sign of pain. In like manner I bury the pin in the skin of the forearm, the arm, the elbow, the face, the head, the thighs, the feet, the chest, the breast, the abdomen, and the back, and everywhere I observe the same insensibility to pain. This woman is, then, profoundly analgesic, and at every point of the cutaneous envelope.

Now, note this. On entering this hospital, some weeks ago, she felt perfectly the pain caused by the pin, as we assured ourselves by different trials ; she has only very recently become analgesic, and I can easily play the prophet by announcing to you that, sooner or later, she will have completely recovered her normal sensibility.

As I hope to demonstrate to you shortly, she has become analgesic in consequence of the syphilis ; and this symptom of *analgesia* will grow faint and disappear along with the other manifestations of the diathesis. Do not think her case exceptional. I have already shown you several patients affected with various disorders of the general sensibility—analgesia, anaesthesia, diminution of the sense of temperature, etc. I will show you others. So, these alterations of the sensibility during the secondary period are common enough in women. I have observed more than a hundred cases during the last two years.

Pathological analogy has, for several years past, led me to investigate the condition of the general sensibility in syphilitic women. Considering that very many poisonings disorder this sensibility in different degrees and in various ways, I questioned if the syphilitic poison might not give rise to like phenomena. I was astonished to find how frequently this was the case, for the phenomena—so well marked, and so easily recognizable—seemed to me scarcely of a nature to have thus far escaped the attention of observers. I can now lay it before you as certain, that in women secondary syphilis *very commonly* gives rise to various disorders of the general sensibility.

Sometimes only the perception of pain is affected, constituting what is called *analgesia*. Sometimes both the sense of pain and that of touch are affected, rendering the patients at the same time analgesic and anaesthetic. In still other cases, but more rarely, the sense of temperature is altered.

Simple isolated analgesia, with preservation of the senses of touch and of temperature, is the most common of these disorders. Such, for example, is the case of the patient I have just shown you. The woman, as you saw, is profoundly anal-

gesic ; but, while not feeling pain from the prick of the pin, she is quite aware of its contact, which she can accurately locate. It is the same, if you merely brush lightly one of her fingers. In short, she is analgesic, and analgesic only.

Another form, somewhat less frequent, is *anæsthesia combined with analgesia*. Here is another woman who contracted syphilis several months since, and who now, as you see, presents numerous symptoms of it. She is analgesic, for she shows no pain when I thrust a pin through the skin of the dorsal surface of her hand. She is, moreover, anæsthetic. I touch her lightly on one after another of her fingers, and she tells us she has felt nothing. It is only on my exerting a certain amount of pressure on the points I touch, that I should succeed in giving her the sensation of contact.

It is a curious fact that, while analgesia is frequently met with without anæsthesia, the converse does not occur. It seems that anæsthesia cannot exist alone. Thus far, at least, I have never met with such a case.

There is a third variety. Here is another woman, who not only is analgesic, but in addition has lost the *sense of temperature*. We place on the back of her forearm two thimbles, the one filled with very hot, and the other with very cold water. She feels neither the coldness of the one nor the heat of the other. She endures the contact of flame for several seconds. Within a few days she burned herself severely by handling a very hot iron, the high temperature of which she had not appreciated.

Of these various disorders of sensibility, the most common, as I have told you, is analgesia, either alone or associated with anæsthesia. Let us, then, study this analgesia with some minuteness. In *degree* it shows numerous varieties. Sometimes it consists only in a slight impairment of the sensibility to pain. Sometimes, on the other hand, there is observed a complete, absolute abolition of the sense, as in the first two patients that I have just shown you. Between these two extremes a great number of intervening stages may be met with.

As regards location, there is the same variety. In some cases it is general, extending from head to foot. In others it is confined to particular regions. It is then almost invariably found limited to the extremities of the limbs, *i. e.*, to the hands, the lower half of the forearms, the feet, the ankles, &c. A very curious trait is, that occasionally this analgesia is still more closely circumscribed, being confined to a special region—the *back of the hand*, over the dorsal surface of the metacarpus. We have often met with analgesias of this sort, whilst in the

immediate neighborhood and throughout the whole integument the normal sensibility was unaffected. This singular localization of the syphilitic anæsthesia to the dorsal surface of the metacarpus, or of the hand (for in some cases it extends to the back of the fingers), is certainly one of the most interesting phenomena, and one that we observe here almost daily. It is on this part that we first seek for analgesia, for it always exists here when it does anywhere, and often here alone, though wanting everywhere else. When the disorder is general, or more extensive, it most frequently attains its maximum at this point, the dorsal surface of the metacarpus, and it is from this point that it disappears the latest.

Syphilitic analgesia is generally superficial and exclusively cutaneous. Thus, irritations involving only the skin are not perceived; but they are felt as soon as they reach the cellular tissue or the subcutaneous nervous bulbs. Most of our analgesic patients are sensible to pinching, but some feel neither pinching nor twisting.

These disorders of sensibility are generally, but not invariably, symmetrical. We have seen some cases of very curious irregularity—for instance, one young woman is analgesic on the back of the left hand, and on the ring-finger alone of all the fingers; everywhere else the sensibility is unaffected.

So far as I have observed, these disorders show a preference for the *early months* of the secondary period, and generally accompany other manifestations of the diathesis. They are always, or nearly always, of rather long duration, rarely lasting less than several weeks, most frequently two, three or four months, and even longer in certain rebellious cases.

Probably you have already asked yourselves if these disorders of sensibility really proceed from syphilis, or if they may not have some other origin. It would be possible that such manifestations should proceed from other causes than syphilis, especially in women; that, for instance, they should be the result of chloro-anaemia, hysteria, nervousness, &c.; in which case, they would be only pure coincidences, and have no connection with the syphilis—the expressions of some pathological state accidentally developed in syphilitic subjects.

Be assured that such was not the etiology of the cases we have just been studying. These derangements depended neither on chlorosis, nor on hysteria, nor on nervousness, nor on any other analogous cause; and this for a reason as simple as it is peremptory, viz., that none of the patients presented any of the attributes of chlorosis, or hysterical antecedents, or habitual disposition to nervous troubles. Was it not rational,

for this reason alone, to impute the symptoms to that morbid cause, to the action of which these patients were in common subjected?

Moreover, there are other reasons, which, it seems to me, should very logically lead us to view them as syphilitic. Here are the reasons, in few words:

1. In the first place, the very frequency of these disorders in women during the secondary period of syphilis. Would they be so common if they were mere accidental coincidences? Common sense rejects the idea.

2. In the second place—a more convincing and more strictly clinical fact—their development in constantly similar conditions. We see them show themselves in the secondary period of syphilis, and in the early months of this period, coincidently perhaps with other syphilitic manifestations of different sorts (cutaneous eruptions, mucous papules, glandular enlargements, &c.),¹ perhaps with other phenomena of the same nature, affecting the nervous system. It would be very singular if, forming part of such an *ensemble*, these disorders of sensibility should figure only as foreign manifestations, by the mere fact of coincidence.

3. In the third place, there is the very evolution of these disorders. Appearing simultaneously with other manifestations of an evidently syphilitic nature, they behave, if I may say so, like these latter manifestations; they last while the others last, they grow less and disappear with them; they yield to the same influence, whether treatment or time. In a word, they are identical. Why deny them that syphilitic essence, undeniable to the pathological group of accidents of which they form a part?

And, moreover, is it surprising that syphilis should awaken such disorders? Is it not a disease which, especially in women, influences in the highest degree the nervous system, and disorders it functionally in a thousand different ways? Do we not see similar phenomena produced in a great many poisonings, the saturnine, the arsenical, the alcoholic, &c.? Pathological anatomy bears testimony in favor of the opinion which we here maintain, and authorizes us in believing that the syphilitic poison may, equally with other poisons, modify the sensibility.

¹ Not long since, the translator had under treatment a case of this affection, immediately following convalescence from an attack of syphilitic iritis. The analgesia was limited to the lower extremities, and was associated with slight anæsthesia. The patient was a woman of about 35 years of age, without neurotic antecedents.

ON SYPHILITIC FEVER.

BY E. LANCEREAUX.

M. LANCEREAUX thus summarizes the observations of Dr. Edm. Güntz, as expressed in *Küchenmeister's Zeitschrift* :

Peculiar to acquired syphilis, this symptom is not observed in the child hereditarily affected, for the very good reason that it belongs to the early period of the disease, and comes on rather soon after the appearance of the chancre. Ordinarily it shows itself from the 20th to the 65th day after infection, provided the patient has not previously been subjected to the mercurial treatment. The fever appears without appreciable exciting cause, or in consequence of a cold, or of dietetic imprudence. It may be confined to mere thermometric phenomena, without causing any subjective symptom ; but generally it is otherwise, being often accompanied with fatigue, pains in the limbs, headache, sleeplessness, thirst, loss of appetite. It is generally ushered in by a more or less severe chill, followed by acceleration of the pulse and elevation of temperature ; sometimes a slight intestinal catarrh appears at the same time. The fever goes on increasing for a day and a half, two, and rarely three days ; arrived at its height, it speedily diminishes and entirely disappears after an abundant perspiration, unless indeed a fresh exacerbation occur. A rather common prodromic symptom of an exanthematous eruption, especially of roseola, this fever announces itself in the evening by an increase of half a degree in the temperature over that of the morning. Thus in light cases it gives in the evening 38° (centigrade), in the morning 37.50° . In other cases the thermometer indicates 39° , and even more, but never as high as 40° .

The pulse increases in frequency, but never reaches 110. Often the secondary syphilitic eruption does not become distinct or reach its greatest intensity until the fever is beginning to abate, as is observed in variola and in measles. The syphilitic fever always differs from the fever of measles and from that of small-pox ; not only is it of shorter duration, and does not generally cause so great a rise of temperature, but, in addition, the time which elapses from the commencement of the fever until the appearance of the exanthem is commonly shorter in

syphilis than in small-pox and measles. Swelling of the glands commonly appears at the same time with the syphilitic fever. Frequently, even after the cessation of the syphilitic fever, an elevation of temperature, or a return of the febrile condition, is caused by the appearance of an angina, or of a papular or pustular eruption.—*Annales de Dermatologie et de Syphiligraphie*.

ON A SKIN DISEASE HITHERTO UNDESCRIBED.

PAPILLOMA AREA-ELEVATUM.

BY DR. HERMAN BEIGEL,

Physician to Metropolitan Free Hospital, London.

TRANSLATED FOR THIS JOURNAL FROM VIRCHOW'S ARCHIVES.

ON the 6th day of April, 1869, I presented to the London Pathological Society, and on the 14th of April to the Hunterian Society, a patient afflicted with an interesting and as I believe thus far undescribed disease of the skin.

As my observation has been confirmed by two such authorities as Hilton Fagge and Jonathan Hutchinson, it might be considered as settled that it is indeed a new form of skin disease.

The patient, Samuel Thompson, 12 months old, was the first child of healthy respectable parents. As far as could be ascertained by a very minute examination, the parents of the child had never had syphilis nor any serious skin disease. The little patient was healthy from birth, until the age of ten months, and then without any traceable cause, he was seized with convulsions. On the first day he had 17 attacks and in the following night six, when the mother, very much alarmed, sought advice at the Child's Hospital of this city, and the child was given a medicine by the use of which the attacks became less frequent. On the 2d of March, 1869, the child came under my care, at the St. Pancras Dispensary.

At the examination I found the little patient of rather stout build, but badly nourished. The mucous membranes were pale and the muscles flabby. The last attack took place a fortnight previously. At the same time the mother noticed small elevations on the child's body, which had grown rapidly to the size I found, when the face, arms and legs presented a number of round macular elevations of the skin: the largest of which was an inch in diameter. On the left side of the face there were twelve such maculæ, which extended from the ear along the lower jaw as far as to beneath the chin. There were also four upon the right arm, two upon the left, six upon the right leg, four upon the left

leg, and one upon the penis. Besides these large maculæ, there was a very large number of small elevations of the size of a head of a pin, or of a pea, from which the larger spots had evidently developed, which fact was confirmed by the mother's statement. The small as well as the larger spots were hard to the touch, and if pierced by a needle, blood and a species of plastic lymph were the only fluids which escaped. Pus could not be detected. The spots had the appearance of buttons formed by elevation of the skin itself. The surrounding integument appeared normal. The largest number by far of these spots had a smooth surface, at the most only slightly fissured, while in some places there was a thin crust in the middle of which was a thicker one. If these crusts were removed, which was easily done, the surface beneath presented the appearance of sponge; and we could recognize the papillæ, which were very much hypertrophied, grouped side by side, and saturated with serum.

The sensibility was diminished in an extreme degree, for I cut off one of the spots at the base with a knife, causing much bleeding, without the child crying or showing any symptom of pain. The portion thus shaved off, in its fresh condition, could be readily used for microscopical examinations, and the specimens I have demonstrated at the Pathological Society.

The result of the microscopical examination can partly be predicted by the macroscopical appearance. In the vertical section, the papillæ were seen to be enormously enlarged, but their tissue was in a condition of dissolution. At the same time there was to be seen a very perceptibly increased formation of epithelial tissue in and around the pars papillaris, and the integument above seemed thickened, but otherwise of normal condition. In the horizontal section the pars papillaris appeared to be entirely replaced by epithelial debris.

The child has now been under my treatment about six weeks, during which time many of the spots have entirely healed, while others are developing. The healing process begins by the formation of thin crusts, which fall off and are replaced by smaller ones, so that some of the spots on the left side of the face are now reduced to the size of a large pea, and are covered by dark brown crusts. The development of the spots, which were small at my first examination, progresses simply by a larger number of the papillæ becoming hypertrophied, until the patch has reached a certain extent, when the process ceases. The lesion is not attended by itching, or inflammation either in its evolution or decline.

The only known affection of the skin, which the lesion above described in any way resembles, is *Molluscum Simplex*; but this resemblance is only in external configuration, while the microscopical structure is entirely different.

Rokitansky¹ describes the *Molluscum Simplex* as a "purse shaped pendulous protrusion, beginning as a soft elevation."

"It consists of a jutting out of the cutis, which is protruded by an accumulation of young gelatinous connective tissue, in its deepest meshes. This new formation increases and develops itself into masses of a fibrous texture, prolongations from which ramify in the surrounding tissue, and can be enucleated from their cuticular sac in the shape of a fibrous tumor." Cazenave

¹ Pathological Anatomy, Vol. 2d, page 68.

and Schedel¹ found *Molluscum Simplex* to consist of fibrous tissue, while Gustave Simon² as the result of the investigation of several cases observed, found like Rokitansky, only connective tissue.

These observations, however, as well as those of other dermatologists upon the same subject, do not agree at all with those of the lesion above described. Some of the spots upon the child, especially after the formation of the crusts, remind the observer somewhat of *rupia*. I simply mention this, without thinking it necessary to draw a closer differentiation. It is sufficient to remark that the spots which I cut off for microscopical examination, grew again in a few days, and have taken their former shape exactly. I have chosen for the disease the name of *Papilloma Area-Elevatum*, because it seems to express the three main symptoms of the lesion; namely, alteration of the papillæ, circular outline, and elevation above the surrounding skin.

I conclude this communication with the remark, that the fact is of no small importance that the skin disease under consideration was developed during an affection of the central nervous system.

On former occasions I have called attention³ to the fact that nervous affections have a tendency to reflect upon the nerve-centres as well as upon their periphery, which accounts for the fact that diseases of the nerves are frequently coincident with cutaneous lesions. The greater number of cases of this kind which I observe, the more do I become convinced of the correctness of this view.

CASE OF ACUTE INFLAMMATION OF THE CEREBRAL ARTERIES DURING SYPHILIS

AUTOPSY BY DR. MOXON.

THE following case is one of great significance, both as regards the clinical fact of syphilitic disease of the brain, and as regards the pathological question of the relation of syphilis to

¹ *Abrégé pratique des Maladies de la Peau*, Paris 1847, page 436.

² *Haut Krankheiten* 18⁷¹, page 235.

³ See my article upon *Albinismus* and *Nigrismus*, *Virchow's Archives*, Vol. 43, page 530.

arterial disease. Syphilitic node or "gumma" of the brain is amongst the best attested diseases ; but the evidence which should prove that syphilitic inflammations directly attack the cerebral arteries is as yet far from conclusive in its extent. Meanwhile the individual cases that have been published by Dr. Hughlings Jackson (*Med. Times*, 1866), and Dr. Moxon (*Guy's Hosp. Rep.*, 1867), although very few, are of a convincing character. The case which we are about to describe occurred in Guy's on July 31st, and is a very convincing example of acute syphilitic arteritis. The patient was a man, æt. 31, who was admitted July 29th, under the care of Dr. Fagge. He had suffered from syphilis, and had had headache for some months. He was seized at mid-day on the 29th July, with an apoplectiform attack. He was found to be unable to speak, and this neither from aphasia nor aphonia, but because he could not move his tongue. He had great difficulty in swallowing. His lips were weak, and the saliva dribbled from his mouth. His right limbs were almost completely paralyzed ; the left were weak. The heart's sounds were natural. He died about 24 hours after admission.

On examination of the body, Dr. Moxon found on the middle of the frontal bone a node, quite recent, in the form of a round patch of the size of a shilling and one-fifth of an inch in thickness ; it was in the deep layer of the pericranium, resting on the bone ; its deeper part was yellowish and opaque, and its superficial part minutely vascular ; the bone itself was rather rough and porous-looking, and injected at the corresponding spot. This patch had all the characters of a syphilitic node on the bone. The surface of the cranium was uneven from older nodes. The dura matter was healthy. The arachnoid was rather thickened about the base of the brain and along the Sylvian fissure, but not at the vertex. Some of the cerebral arteries were diseased in a very remarkable manner. The basilar artery especially had its size increased greatly, and its color was of a milky white, so that for a length of three-quarters of an inch it looked like a piece of boiled maccaroni ; but its color was at points more opaque, and its surface rather more irregular. The right vertebral artery was very small ; the left was proportionately large, and it was thickish and rather opaque and stiff. The change in the basilar artery was rather abrupt at both ends of the affected patch. On opening up the basilar artery, the channel was found to be continuous through it, but narrowed to half its natural size from the swelling of its walls. These were soft and fleshy, having all the qualities of firm lymph. The microscope showed that the lymph-like ap-

pearance was not deceptive, for the swollen wall of the vessel was composed of closely aggregated corpuscles, having all the characters of inflammatory corpuscles ; these were in layers between swollen remains of the proper coats of the vessel. Thus there was no doubt whatever of an acutely inflamed state of the arterial wall, and the correspondence of the lymph on the arterial wall with that in the pericranial node was marked enough. There were two spots on the left Sylvian artery showing the same remarkable inflammation in an earlier stage. The substance of the pons varolii was swollen, and its parts indistinct as though running into each other, yet no breaking down had actually occurred ; section through it showed, when submitted to a very feeble stream of water for a moment, a noticeable degree of softening on the left side more than on the right. The portion of brain corresponding to the left Sylvian artery was rather soft. The other organs of the body did not yield any point worthy of notice.

Dr. Moxon considered the occurrence of so acute a form of arteritis as in itself very interesting and very important. The disposition at present, he thought, is too much to regard all changes in the arteries as of a chronic and degenerative kind. When the inside of an artery is found defaced by atheroma and cartilaginous thickening, this is set down as the result of senile atrophic changes. Such chronic and degenerative changes are even commonly held to be the cause of aneurisms. He believed that this view of arterial pathology is (*sic*) very far from being correct. As to aneurisms, they often occur in young people, and the softened and thickened tracts of the arterial wall that accompany the aneurisms are found, on microscopic examination, to be infiltrated with inflammation corpuscles ; so that, in short, many aneurisms, if not all, are accidents of arteritis. So, too, he believed that the deformed senile arteries, that were viewed as degenerate, may (*sic*) be in many cases at least not degenerative and progressive, but rather remains of by-gone inflammation of the arterial coats, corresponding to old thickenings of the pleura, periosteal nodes, &c. This is not a new view, at least as regards the inflammatory nature of arterial diseases. The presence of inflammatory corpuscles in the walls of these arteries has been asserted by numerous observers, especially in Germany, and Dr. Moxon has verified the presence of these corpuscles in many examples. But the arteritis in the present case differed from the ordinary forms of thickening of the arteries. It affected all the coats, and the amount of the lymph formation was very unusual. The occurrence of this remarkable arterial disease along with periosteal nodes in a

syphilitic patient is another important instance establishing the power of syphilis to cause acute disease of the arteries.—*Lancet*, Sept. 25, 1869.

Epitome of Current Literature.

Chromidrosis.—Dr. A. W. Foot publishes some very interesting observations on chromidrosis, with a tabular statement of 38 cases, including two of his own. It appears that women are the most frequently affected, in the proportion of eight to one; and the unmarried twice as often as the married. The average age of patients at the time of attack was 22 years. It is generally preceded by uterine disorder or some cachexia. The coloring matter has many chemical and microscopical characters in common with the indigo compounds. Indican (a substance which yields indigo) exists in the blood in certain abnormal conditions, and having been eliminated with the perspiration, undergoes dehydrogenation and subsequently (in various degrees) oxidation into brown or blue indigo. The blue may be so abundant as to appear black.—*Dub. Quar. Jour. Med. Sci., Aug., 1869.*

Ephemeral Congestive Tumors of the Skin.—Dr. Perroud gives five cases of his own, and quotes two published by Graves. They usually appear upon the face. The patient first feels, in that portion of the skin in which the swelling is to appear, a sudden abnormal sensation—either a sense of coolness, of tension, of tickling, or of slight pain. In a few hours a hard, hot, indolent, pale-reddish or colorless swelling appears, and may attain the size of a turkey's egg. There may be more than one tumor. In a few minutes, or a few hours, they entirely disappear, leaving the skin in a normal condition. They are attributable to a diathesis, or to visceral (generally uterine) disturbance, which alone should be the subject of treatment.—*Annales de Dermatol. et de Syphilig.* 1, 3.

Elephantiasis of the Nose.—Dr. Guibout recommends the following treatment for elephantiasis or hypertrophy of the nose. Every three or four days make from six to eight deep punctures with the lancet into the hypertrophied part, then apply finely-picked lint saturated with an astringent solution and retained *in situ* by a bandage, passing round the head, and exerting as much pressure upon the parts as practicable. Dr. G. uses a concentrated solution of the muriate of ammonia, and

keeps the lint constantly moistened. Other astringent solutions, as of tannin, alum, or the persulphate of iron would probably answer as well. This treatment will require three or four months, in severe cases, but, if as successful with others as in the hands of Dr. Guibout, it is a valuable accession to the therapeutics of this distressing and obstinate affection.—*Annales de Derm. et de Syph.*

The Ligature Treatment of Elephantiasis Arabum.—Dr. Fischer, of Hanover, has tabulated the results of 21 cases (intended to be all that are on record) treated by this method, which was first proposed in 1833, by Dr. Dufour, and advocated in this country by the late Prof. Mütter, of Philadelphia; of these 21 cases, nine were entirely, and two very nearly, cured; two showed improvement; and seven were unaffected, or resulted in death. The list of successes includes one case treated by digital compression, and reported by Vanzelli.—*Virchow's Archiv*, XLVI. 3.

Post-Mortem Change of Color in the Hair.—Prof. Sonnenschein (quoted by Dr. Hauptmann), states that decomposition of a body, long buried in the ground, is accompanied with a change of dark-colored hair to red, the hair showing also an acid reaction.—*Virchow's Archiv*, XLVI. 4.

Features in the Etiology of Herpes Zoster.—Mr. Hutchinson reports eight cases of herpes zoster, which arose during the treatment of other diseases by arsenic, and apparently in consequence thereof, as he has only twice observed the development of the disease during the course of other cutaneous diseases, where arsenic had not been employed. These two cases were respectively scabies and eczema. His theory is somewhat weakened by the fact that the herpes zoster went on to recovery in the usual manner, even when the arsenic was continued. He considers that the roots of the sensory nerves may be so affected by special abnormal conditions of the blood as to occasion the peculiar peripheral irritation necessary to cause the eruption. He looks upon herpes zoster as holding an intermediate place between an exanthem and a neurosis. He mentions syphilitic herpes zoster, in which the groups of vesicles correspond with the nervous distribution, but are bilateral, and accompanied by others on different parts of the body. These cases are of much longer duration than the non-specific form.—*Med. Times and Gaz.*, Dec. 26, 1868, and Apr. 17, 1869.

Herpes occurring during an Arsenical Course of Treatment.—The following case seems to favor the views of Mr.

Hutchinson regarding the production of shingles after the internal administration of arsenic. A woman affected with chronic psoriasis, who some time previously had been treated by large doses of arsenic, but had been compelled to discontinue the remedy in consequence of suspicious symptoms, came under the care of Dr. Duffie on Sept. 3d. Smaller doses of the liquor arsenicalis (three minims to be taken thrice daily) were ordered; and this treatment was continued up to the 19th, when itching of the conjunctivæ and a whitish tongue indicated the full action of the remedy upon the system. At the same time the patient complained of an aching pain in the right shoulder and elbow, which on the following day was associated with a copious and well marked eruption of herpetic vesicles over the integument of the arm and forearm. No other part of the body was similarly affected.—*Lancet*, Oct. 1869.

Case of Measles followed by Diphtheria—Death.—Dr. Fagge reports the case of Sarah C——, æt. two years, who was admitted into the Evelina Hospital for Sick Children, with ecthymatous sores over the body and legs. Thirty days afterwards, there having been cases of measles in the ward, she showed the eruption of rubeola. She progressed favorably for four days, when there appeared a diphtheritic membrane covering the right conjunctivæ. It had reformed on the following day, and the cornea was yellow, as if suppurating. A harsh dry cough is mentioned, but no throat symptoms. She died on the 8th day from the appearance of the eruption, and at the autopsy, five hours after death, the back part of the tongue, and the soft palate and tonsils were found covered with a uniform layer of yellowish membrane, which extended to the epiglottis, lining the anterior surface up to its very edge, but not invading the laryngeal surface. The larynx was healthy. The lungs showed traces of broncho-pneumonia and capillary bronchitis. The spleen weighed 2 1-4 oz., and was firm on section. On the day after the patient's death, her nurse, æt. 44 years, was taken ill with what proved to be a mild attack of pneumonia.

The two cases are given together to illustrate some introductory remarks questioning whether "different states of the recipients may not determine that a certain poison shall produce measles in one, diphtheria in another, pneumonia or pleurisy in a third, while in a fourth the factor from without, finding no corresponding internal factor, shall produce no appreciable result, or at most a result which may only be evidenced in after years by an apparent insusceptibility to some poison."—*Lancet*, Sept. 25, 1869.

Acute Pemphigus from the use of Copaiba.—M. Hardy reports the case of a young man with blennorrhagia treated with copaiba capsules. In a few days the remedy was suspended in consequence of an erythema. The discharge, which had ceased with the eruption, returned, and the copaiba was resumed. After 14 days a modified pemphigus appeared at the flexures of the joints, and became general. The bullæ on thin-skinned parts aborted; where the skin was thick they developed regularly. The discharge was profuse, offensive and viscid. There was concomitant diarrhœa, and the perspiration had the odor of copaiba. The urethral discharge was in inverse ratio to the cutaneous. The pemphigus disappeared in six weeks, by desquamation. The treatment was emollient.—*Gazette des Hopitaux*, 1869. 37.

Lichen Planus.—Under this term Mr. Erasmus Wilson describes an affection which consists in “an eruption of papules remarkable for their color, their figure, their structure, their habits of isolated and aggregated development, their habit at their local and chronic character, and for the melasmic stains which they leave behind them when they disappear.”

Their color “is a dull crimson red, more or less vivid, with a purplish or lilac tinge.”

In figure they are “flattened, smooth, and depressed on the summit, angular in outline, only slightly elevated, and of a size varying between one and three lines in diameter.”

In structure the papule is a “hyperæmia with exudation, surrounding a follicle and covered by a thin layer of horny transparent cuticle.”

The papules may be discrete or aggregated, forming a patch with the cutaneous interspaces in an infiltrated condition.

Lichen planus is frequently “met with on the front of the forearm, just above the wrist; in the hollow of the loins; on the lower half of the abdomen; on the hips; around the knees; on the forearms and calves of the legs; and in women around the waist, and in the grooves caused by the garters.”

The disease is essentially chronic and “has no constitutional symptoms of its own, and frequently prevails with very little constitutional disturbance of any kind.”

“The melasmic discoloration of the parts where the eruption has existed and where it has disappeared is a characteristic feature, and may be accepted as a pathognomonic character, when taken in association with the signs already considered.”

Mr. Wilson gives short histories of some fifty cases which have fallen under his notice.

In reference to treatment he considers that “our first object

should be to regulate the functions of the economy wherever any disorder may be apparent ; in the next place we should endeavor to restore the vigor of the system, by tonic remedies such as bitters, quinine, nitro-muriatic acid and chalybeates ; and, these objects being effected, we may finally have recourse to the tonic-nutritive operation of arsenic. Locally the most reliable remedy is a solution of the perchloride of mercury in emulsion of bitter almonds, in about the proportion of two grains to the ounce. It is important before using the latter remedy to stimulate the eruption by friction ; and in the instance of the desquamating confluent patches, to remove as much of the scale and sordes from the surface as possible by means of a thorough saponaceous ablution."—*Journal of Cutaneous Medicine*, No. 9.

Cutaneous Eruptions due to Bromide of Potassium.—M. Voisin has observed in 96 cases of epilepsy treated with bromide of potassium, five different kinds of cutaneous eruption, which he imputes to the action of the drug, viz., (1) *Acne*, which is the most common, is preceded by itching ; mostly affects the face and chest ; occurs most frequently in full-blooded persons ; and is unaffected by the season. The use of diuretics, together with a lotion of flax-seed tea, was found to keep the eruption in abeyance, without the need of suspending the bromide. (2) A *peculiar eruption*, which occurred in six cases, and consisted of little tumors formed by groups of very indolent acne-like pustules, generally seated on the legs ; inflamed at the base, and depressed at the centre ; painful to the touch (except at the centre) ; tardily discharging a matter like that of furuncles ; healing slowly, and leaving cicatrices which, when seated over a bone, are painful on pressure. They occur oftenest in the winter, and are accompanied by acne over the body. Early incision was of no benefit ; but rest, and the application of poultices and opiated cerate, are recommended. (3) A variety of *urticaria*, occurring in two instances, and somewhat resembling erythema nodosum. It occurred only after long continuance of the bromide in large doses. (4) *Furuncles*. (5) A very moist *eczema* of the legs, with pityriasis of the scalp.—*Gazette des Hopitaux*, 1868.

Dermatalgia.—Dr. H. S. Purdon thinks that neuralgia of the skin, which he has most commonly observed affecting the left side of the body, and manifesting itself in hyperæsthesia, is often of hysterical origin. He has seen it, confined to the hands, in a case of cerebro-spinal meningitis, and quotes Marcé to the effect that, in a severe and long continued form, it is one

of the early symptoms of myelitis.—*Jour. of Cutaneous Med.*, April, 1869.

Area Celsi.—Dr. Scherenberg reports two well-marked cases, in which no parasite was found, or any unusual appearance of the skin, but only changes of nutrition in the hairs, which were attenuated, without brittleness, easily detached, and furnished with very slight, if any, bulbous expansion at the root. The epithelial sheath remained in the follicle, and there was absence of pigment near the root.—*Virchow's Archiv*, XLVI. 4.

Dermatitis Toxica.—This name has been given by Mr. Erasmus Wilson to a cutaneous affection caused by wearing stockings dyed red with coralline. He reports three cases, in each of which the stockings had been worn only a short time; in one instance for only one day. At first there was an inflammation, more or less severe, with extensive multilocular vesication, mostly limited to the soles and sides of the feet, and accompanied by intense pain and itching, which for many weeks rendered locomotion impracticable. Lichenous and eczematous eruptions, which are often developed on other parts of the body—particularly the hands—Mr. Wilson considers to be reflex, and not due to the direct contact of the poison. In the way of treatment nothing specially worthy of note is suggested. Tardieu and Roussin have experimented with coralline (the only vegetable dye known to be poisonous), and consider it an irritant poison comparable to croton oil. A dog was killed in thirty-six hours by some of this substance extracted from stockings. In man the poisoning has thus far shown itself only in local symptoms, what general disturbance there was being probably due to the local disease. Yet it is considered probable that in these cases a portion of the coralline is absorbed.—*Jour. Cutaneous Med.*, April, 1869.

Eczema in Aged Persons.—Dr. H. S. Purdon furnishes some notes on eczema, with special reference to the disease as it occurs in old persons. After stating that, in old age, "the epidermis is rough, dry and impermeable," and quoting Dr. Day to the effect that "it almost acts as a foreign body, and keeps up a perpetual irritation on the subjacent papillæ in the true skin," he goes on to say that, in such cases, "the application to the skin of a common pitch-plaster, or a stimulating ointment, is frequently sufficient to occasion an amount of local irritation which rapidly ends in an eczema."

"The inflammation usually ends in subcutaneous infiltration and becomes chronic." He attributes the frequent occurrence

of eczema on the shins of old people to their habit of constantly sitting close to the fire. He states that the occurrence of a crop of furuncles around the margin of the diseased part is an occasional accompaniment of convalescence. For the eczema about the arms, in "good livers," accompanied with hæmorrhoids, constipation, &c., he uses the confection of black pepper, with the local use of dilute citrine ointment. For the eczema intertrigo of the scrotum and inside of the thighs, in old men, with incontinence of urine, he employs Hebra's absorbing powder of starch and oxide of zinc. In eczema occurring as a concomitant of lumbago he has derived considerable benefit from the use of tincture of *actæa racemosa*, combined with Fowler's solution. After mentioning that in the eczema of the aged it is generally necessary to give arsenic, here commends the liquor sodæ arseniatis as least likely to derange digestion. For dissolving the hardened cuticle "in very inveterate cases" he uses a solution of chromic acid (20 grains to the ounce), applied night and morning. To allay excessive itching, he recommends the application of butter-milk, in which water-cresses have been boiled.—*British Med. Jour.*

Tracheotomy in Syphilitic Affections of the Respiratory Passages.—M. Trélat thus sums up the conclusion of a series of papers on this subject. 1. Syphilitic affections of the respiratory passages which require tracheotomy may appear at any stage of syphilis, but are most frequent in the tertiary period. Their nature, seat, and extent vary; but they are most common in the upper part of the larynx. 2. The occurrence of obstruction may be rapid, but is usually slow, and should be attentively watched, because it gives an element of diagnosis. 3. An attentive study of the symptoms and signs of obstructions of the larynx and of the trachea demonstrates that it is possible to distinguish two orders of lesions, which are so important to recognize for prognostic and therapeutic purposes. 4. Their diagnosis rests on the retention or the loss of the voice, on the period at which dyspnoea commences, and on laryngoscopic examination. 5. Tracheotomy gives excellent result in laryngeal obstructions. So far it has proved of very different value in tracheal narrowings. 6. When the operation is indicated it must be done without delay, for fatal suffocation may occur suddenly. 7. Though tracheotomy offers little prospect of success in tracheal narrowing, it should nevertheless be attempted, subject to rectification of diagnosis during the course of the operation. 8. The operation may be modified according to the nature of the lesions, and success can only be hoped for when it is possible to pass through and dilate

the stricture with a proper canula. 9. When tracheotomy is followed by cure, the time for which the canula must be kept in varies directly with the lesions. The indication is to withdraw it as soon as it is safe after the operation, and to pursue a constant medical treatment. 10. The employment of M. Broca's canula (with an opening limited during inspiration) allows of an exact appreciation of the moment when we may withdraw the tube, and allow the wound to close, without danger.—*Gazette Hebdomadaire, May, 1859.*

Therapeutical Notes.

Treatment of Eczema.—Mr. Erasmus Wilson very concisely states the disease, in a therapeutical point of view, to be a cutaneous hyperæmia, followed by the various lesions of epidermal exfoliation, exudation, infiltration and incrustation and lays great stress upon the recognition in the lesion of the indications for treatment. In illustration he cites an ordinary case of eczema of the leg, presenting in one spot, hyperæmia and œdema, in another, a raw weeping surface, in still another merely desquamation and perhaps a few scattered papulæ. In this complicated condition of the parts he clearly shows the necessity of varied therapeutical applications. We can concisely sum up the indications. 1. The parts should be as far as possible kept in a condition of rest and covered continuously with appropriate applications to prevent any exposure to the air. 2. The discharge should not, under any circumstances, be washed away with water, but gently wiped with some soft fabric. 3. If the pruritus is intense the parts should be gently rubbed with zinc ointment, or a sponge squeezed out in hot water, or what is better, spirit and hot water can be gently pressed to the surface, or applied by means of any thin fabric; but to be replaced with a layer of zinc ointment. 4. Incrustation can readily be removed by the linimentum calcis, applied on a soft brush. 5. The excoriated and exuding surface thus left must be covered with benzoated ointment of oxide of zinc, carefully applied by the point of the finger. 6. Erythematous and papular patches must be carefully dusted with a powder of starch, oxide of zinc and camphor, which acts as a sedative astringent. 7. The whole surface is then to be covered by a retentive bandage neatly applied, which is smeared with zinc ointment (this latter procedure is sometimes difficult if not impossible when the lesion is situated on the pudendum, the axillæ, the neck and the apertures of the body, and behind the ears). 8. In chronic eczema the infiltration is very much diminished by a few applications of quite strong solutions of potassa fusa, or the use of mercurial ointments and the tarry preparation. 9. In the

atonic condition of the skin left by an eczema, much can be accomplished towards restoring its normal condition by the frequent use of the cold douche and saponaceous ablutions, particularly with juniper tar soap. He lays great stress upon the troublesome effects produced by benzoated zinc ointment when used upon the scalp; great as is the field for this efficient preparation on this site, it is inapplicable and troublesome as it dries up the secretions, mats the hair together and forms a very unmanageable cap. He recommends instead, diluted nitrate of mercury ointment or the ointment of the ammonio-chloride. While he minutely describes the local treatment he also advocates a constitutional course. In some cases, however, the lesion is merely of local origin and then only requires topical remedies. He considers as causes of eczema: 1st. A nutritive debility, the result of improper food. 2d. A more active nutritive waste than nutritive supply as in elderly persons. 3d. Errors of assimilation.

In the eczema of children, it is necessary that the diet should be appropriate to their peculiar organism, and a combination of assimilative tonics such as cod liver oil, Fowler's Solution, and wine of iron should be administered. In cases of imperfect assimilation and of tissue waste, attention to the digestive functions with iron and arsenic are the indications. His term of assimilative debility, which in a measure corresponds to Bazin's "Arthritism," requires the correction of any error of oxidation as an excess of uric acid in the blood and general attention to regimen and diet with antacid remedies. He concludes by advising care in the use of arsenic, and that it be held as a "reserve force" and only employed when the animal functions have been regulated by appropriate remedies.—*Practitioner*.

Hypodermic Injections of Arsenic in the Treatment of Psoriasis and Chronic Eczema.—Dr. Edward Lipp has employed arsenic subcutaneously in connection with other treatment, and, in three cases, alone. Of these latter cases, two were extensive psoriasis, and the other a chronic squamous eczema. The remedy was used in the form of an aqueous solution of arsenious acid, $\frac{1}{4}$ to $\frac{2}{3}$ of a grain being injected every second or third day, preferably at the lower part of the back, as there it creates the smallest amount of irritation. The advantages claimed are, the certainty of absorption of the remedy, avoidance of digestive derangement, the small quantity of the drug necessary, and the short duration of the treatment. The benefit, however, is no more permanent than after the internal use of the medicine.—*Archiv. für Dermat. u. Syph*, 1869, III.

Creasote in Psoriasis.—Balmanno Squire thinks that creasote has never been fairly tried against psoriasis, and hence that it has not enjoyed the reputation it deserves. He was dissatisfied with the tar preparations, and hence gave creasote a systematic trial. By a long series of experiments he was at last led to conclude that an ointment composed of two parts of creasote, and one of white wax was the best application, and far better than the officinal ointment. This new preparation possesses great efficacy, and is a more elegant compound than the ung. picis. liquidæ. The diseased skin is less sensitive to the irritating effects of the creasote than the healthy skin.

Squire has tried this ointment in more than one hundred cases; in a few lymphatic subjects the ointment should be made half-and-half; but for all other cases the maximum strength of two-thirds creasote will be found the best.

Arsenic in Herpetic Ophthalmia.—"Mr. R. S. Oglesby's remarks on the herpetic form of strumous ophthalmia are very valuable—chiefly, I think, from the great promise of the remedy which he proposes, and which he has found so useful in practice. I would venture, however, with great diffidence to question whether the name he has given is appropriate to the disease of which he gives so graphic an account. Such symptoms as Mr. Oglesby describes are extremely common in strumous children, but the eruption on the face has always appeared to me more allied to eczema than to herpes. Herpes on the face is, according to my experience, very uncommon, and particularly so in young children. I beg to congratulate Mr. Oglesby on the discovery of a remedy for a disease which is, under ordinary circumstances, very troublesome, and in many cases almost impossible to reach by the remedies in use."—*Mr. W. S. Watson in Practitioner, July, 1869.*

The Abortive Treatment of Erysipelas.—M. Leuroth proposes a new method of treatment of erysipelas. It consists of very superficial linear scarifications upon the surface of the patch with others so as to circumscribe it. The blood which oozes from the cuts is to be smeared evenly over the surface. Should the disease, however, pass over the barrier thus formed it should again be tried at the boundary. The advantages claimed are that the hyperæmia is lessened, and that the film of coagulated blood protects the parts from the air.—*Gaz. Méd. de Strasbourg, June 16.*

Treatment of Acne Rosacea.—Dr. C. B. Mesterten recommends a careful regime in the avoidance of every thing

that may congest the face, such as sitting before an open fire, or exposing the face to cold winds, etc. Internally the treatment should combat any dyscrasia or imperfection of general health that may be present. Locally he employs scarification of the affected part, the depth of the incisions depending upon the amount of hyperplasia existing, and never exceeding two lines. The cuts are made close together and crossing each other. The hemorrhage is slight and easily controlled. The following day he applies a thick layer of collodion. This procedure to be repeated as often as necessary until a cure be effected. If much seborrhœa exists he squeezes the sebaceous matter out of the follicles and applies sulphur ointment at night and in the morning. Ablution with the following mixture: saponis viridis, 12 parts; coneent. alcohol, 200 parts; spirits lavand., 6 parts. In cases of ordinary severity he is usually successful.—*Lyon Médical*.

Carbolic Acid in Skin Diseases.—Dr. Isidor Neumann has experimented extensively in the internal, subcutaneous and topical employment of carbolic acid. He concludes that its use in large doses by the mouth is productive of such serious visceral diseases as to forbid the practice. Hypodermic injection in dogs caused abscess in two instances, followed in one case by fatal pyæmia. Of eight cases of psoriasis treated by large and long continued doses internally, only one (a case of psoriasis punctata) was cured. The others showed slight improvement at first. It is useless in the treatment of the syphilitic diathesis. It increases the activity of the capillary circulation, and is thus of service against the element of hyperæmia; retards the formation of epidermis, and, by its action on the peripheral nerves, allays pruritus. (Dr. Moriz Kohn). Kohn, at the time of writing, had nearly cured with it a case of pityriasis rubra; had generally overcome the itching of prurigo, and had immediately cured a case of pruritus. *Archiv. für Dermatol. u. Syph., 1869, II. and III.*

Ergot in the Treatment of Purpura.—Henoeh's testimony has been corroborated by Dr. Bauer, who has employed powdered ergot, 8-10 grs., from once to thrice daily, in the treatment of purpura. Of course it does not affect the effusion already existing, but after a few days no more spots of extravasation show themselves.—*Deutsche Klinik*.

Pruritus of Pregnancy.—Dr. Léon Gros reports a case of great severity, affecting the entire surface, without eruption, and complicated with pyrosis and dental neuralgia, in which treatment of various kinds was ineffective. Finally a speedy

cure was brought about by the patient's smoking a cigar every night. The same treatment was equally efficacious against a return of the affection during a subsequent pregnancy.—*Bulletin Gén. de Thérap.*, Dec., 1868.

Local Treatment of Ichthyosis.—Mr. J. L. Milton reports two severe cases of ichthyosis, which yielded temporarily to the following treatment: a daily bath of a warm solution of carbonate of soda ($5\frac{1}{2}$ grs. to the gallon), and the following ointment:

Potass. iodidi	℥j.
Ol. pedis bubuli, adipis. <i>a a.</i> .	3 ss.
Glycerinæ	3 j.

To be kept applied until the next bath.—*Jour. Cutaneous Med.*, April, 1869.

The Removal of Warts.—Warts may be readily cured by cutting a hole in a piece of sticking plaster, the size of the wart, applying the sticking plaster so that the wart protrudes, and then using—

Caustic potash	℥ ij.
Gum Arabic	3 ss.
Flour sufficient.	

M.—Make a paste. S.—To be left on for a few hours.—*Baltimore Med. Bulletin.*

Treatment of Scabies.—Mr. Jonathan Hutchinson, in his "Norwegian Notes," states that there were a great many cases of scabies in the hospital at Bergen, where the cure of the disease seemed to constitute a sort of specialty. Dr. Holmboes' treatment is as follows:—The patient is first put into a warm bath, and is afterwards well rubbed with the tar and soap ointment (equal parts of common tar and green soap). Theunction is repeated two or three times a day, and the cure rarely takes more than a few days. Sometimes troublesome eruptions remain afterwards, and in a few cases it is found requisite to resort to sulphur. The same plan is adopted both for young and old.—*Medical Times and Gazette*, August, 1869.

Quinine in Pemphigus.—V. Dieren reports the very unusual (*sic*) occurrence of pemphigus without syphilitic complication. The vesicles made their appearance with sharp febrile symptoms of a quotidian type, the intermissions being very complete. The case was completely cured by quinine in a short space of time.—*Practitioner*, September, 1869.

Treatment of Syphilitic Waxy Liver.—Dr. Wetzlar, of Aix, lays down the principle that there is no way of cure for syphilitic waxy liver, except by specific treatment. If the patient have as yet taken little or no mercury, this is the prin-

cial remedy. The author has himself found corrosive sublimate to be the most rapidly-acting mercurial preparation in waxy liver, where there is a tendency to intestinal catarrh, especially in seasons when diarrhœa is prevalent, and also in patients who are decidedly anæmic. Wetzlar prefers the use of mercurial inunctions. When mercury has already been administered to a sufficient extent, iodide of potassium must be employed, which is only active against syphilis (says the author), when it follows a previous mercurial course. The diet must be nourishing and easily digestible; and, as all patients bear mercurial treatment better if they are not deprived of fresh air, free exercise out of doors is to be recommended. The author especially recommends the use of the sulphur-waters of Aix, together with mercury and iodide of potassium. The patient should drink in the morning, while still in bed, several glasses of the thermal water, fasting; then take a bath; and thrice daily, at meal times, should take $\frac{1}{6}$ grain of the bichloride, or else have an inunction of half a drachm of mercurial ointment every night. If iodide of potassium be given at the same time with this, the patient should take several doses of the iodide during the day, and have the mercurial friction at night.—*Deutsche Klinik der Prakt. Arzt.*, May, 1869.

Sulphurous Acid in Syphilitic Ulceration of the Throat.—The value of sulphurous acid as a therapeutic agent, has been tested by Dr. H. S. Purdon with satisfactory results. A gentleman who had been under treatment by the iodide and bi-chloride of mercury, gargles of chlorate of potass., opium, etc., with unsatisfactory results, was then subjected to sulphurous acid, in the form of spray, to the ulcerated surface, applied three times daily. In three weeks the throat was quite cured.—*British Med. Journal*.

Treatment of Gonorrhœa.—M. Cullerier gives for the abortive treatment of gonorrhœa large doses of copaiba—from four to five drachms a day. This is continued for four or five days after the discharge disappears. When the inflammatory stage is over, he uses the following injection to complete the cure:

Sulphate of Zinc	} a a, gr. xv.
Sugar of Lead	
Water	f. $\frac{3}{4}$ iv.—M.

S.—Inject twice daily.

Or, Alum	3 ss.
Water	f. $\frac{3}{4}$ iv.—M.

S.—Use as an injection twice daily.—*Baltimore Med. Bulletin*.

Treatment of Syphilis by Hypodermic Injections of Mercury.—Dr. Oscar Max Van Mons, of Pachécho, has communicated to the Royal Society of Medical and Natural Sciences at Brussels, a brief account of five cases of secondary syphilis, treated by mercurial hypodermic injections. The longest time required for cure was three weeks, and the number of injections was not above three in any one case. This treatment commends itself by the facility of its administration, but more cases are needed to establish its efficacy.—*Gazette des Hôpitaux*, No. 21, 1869.

Treatment of Pruritus Pudendi.—M. Elleaume mentions several topical applications, with which he has on several occasions been able to overcome this troublesome affection. (1) Frequent ablutions of the parts, followed by the application of starch, either injected in watery solution, or applied to the interior of the vagina in the form of powder, mixed with from one-thirtieth to one-eighth of its weight of nitrate of bismuth. (2) Bathing the pudenda with a decoction of white hellebore, as recommended by Hartmann. (3) The following ointment :

Morphiæ acetat	gr. j.
Chloroform	gr. viij.
Ol. amygdal, dulc	℥ij.
Adipis	3j.

M.—Fiat ung.

S.—To be gently rubbed upon the parts several times daily. In some cases the addition of a little carbonate of soda will be found advantageous. (4) Trousseau's lotion, one part of carbonate of potassa in twelve parts of water ; of this a dessert-spoonful is to be added to a pint of water, and used several times a day. (5) A lotion of one part of corrosive chloride of mercury to 17½ parts of distilled water, with a little alcohol ; of this a teaspoonful may be added to a pint of water. The strength of this and the preceding may be doubled after several applications. (6) In obstinate cases, a solution of one part of nitrate of silver in 210 parts of distilled water. (7) Slight cauterization with solid nitrate of silver in the vicinity of the clitoris. (8) The application of a strong solution of perchloride of iron on compresses.—*Traité Élém. des Maladies des Femmes*.

Therapeutic Action of Cubebs.—The employment of cubebs is still common in this country, either alone or as an adjunct to copaiba, in the treatment of gonorrhœa. The drug has recently been subjected to careful examination by M. Heidenreich with a view of ascertaining whether it possessed the powers attributed to it, and in which of its constituents those powers resided. By treatment with ether he obtained an oleoresinous material, the oil and resin of which he subse-

quently separated. He first experimented therapeutically with the oil, administering seven grains every hour for twenty-four hours. No particular effects were observed, there was no alteration in the urine, and only a slight sensation of heat was experienced in the stomach. The resin had the consistence of honey, and when taken in doses of from 7 to 90 grains, it produced a lively sensation of heat in the stomach, and rendered the urine irritating at the same time increasing its quantity. He further obtained certain white crystals of cubebin destitute of taste and color, which produced when taken internally no sensible effect. Hence, M. Heidenreich concludes: 1. That the diuretic properties of cubebs reside in the resin; 2. That cubebin is inert; and 3. That the volatile oil only produces the irritation common to it with other essences.—*Journal de Pharmacie et de Chimie, September, 1869.*

Another Sensation by M. Auzias Turenne.—This gentleman claims to be able to cause the disappearance of the fluid contents of a suppurating bubo, without effecting any solution of continuity, but by merely brushing on a few drops of some solution. He has contrived to intensify the mystery of the matter by entrusting to the Paris Academy of Medicine a sealed envelope, containing the formula of the solution, doing this to make good his claim to priority. Yet he does not claim entire originality, as he states the remedy to have been mentioned by Pliny and Dioscorides.

Hypodermic Injections of Mercury in Secondary Syphilis.—The following is M. Liégeois' formula for the hypodermic injection of the corrosive chloride of mercury:—

Distilled water	90 grammes . . .	= 23 $\frac{1}{2}$ drachms.
Sublimate	20 centigrammes =	3 $\frac{1}{10}$ grains.
Chloride of Morphia. . . 10	"	= 1 $\frac{1}{2}$ "

One of Pravaz' syringes holding one gramme (15 $\frac{1}{2}$ minim.), will contain a little more than two milligrammes (about $\frac{1}{32}$ grain) of the sublimate. Ordinarily there is no inflammation following the injection.—*Arch. Gén. de Méd., Sept., 1869.*

The Application of Electricity in Hydrocele.—M. Friedenthal states that he completely dispersed the hydrocele in five cases by the application of a galvanic current, and that after eight months no relapse had occurred in any of the cases. The current was applied in the usual way.—*Practitioner.*

Bibliography.

Atlas of Venereal Diseases. By M. A. Cullerier. Translated from the French. With notes and additions. By Freeman J. Bumstead, M. D. With one hundred and forty-five beautifully colored figures on twenty-six plates. Philadelphia: Henry C. Lea.

A Treatise on Venereal Diseases. By A. Vidal (de Cassis). With colored plates. Translated with annotations. By George C. Blackman, M.D. Third edition. New York: William Wood & Co.

The Student's Book of Cutaneous Medicine and Diseases of the Skin. By Erasmus Wilson, F.R.S. New York: William Wood & Co.

Manual of Diseases of the Skin. From the French of M. M. Cazenave and Schedel. With notes and addition. By Thos. H. Burgess, M.D. Second American edition, enlarged and corrected from the last French edition with additional notes by H. D. Bulkley, M.D. New York: William Wood & Co.

Diseases and Injuries of the Eye; their Medical and Surgical Treatment. By George Lawson, F.R.C.S. Philadelphia: Lindsay & Blackiston, 1869

Strong Drink and Tobacco Smoke; the Structure, Growth, and Uses of Malt, Hops, Yeast, and Tobacco. By Henry P. Prescott, F.L.S. London: Macmillan & Co.

The Practitioner for November, 1869. New York: Macmillan & Co., 63 Bleeker street.

American books and papers for Review may be sent directly to the Editor, or to care of F. W. Christern, the publisher, No. 77 University Place, New York.

Foreign books for review may be addressed to the following agents of the publisher, who will forward them immediately:

LONDON—Messrs. Williams & Norgate, 14 Henrietta-street, Covent Garden, W. C.

PARIS—Mr. Cs. Reinwald, 15 Rue des Sts., Pères.

LEIPZIG—Mr. L. A. Kittler.

THE AMERICAN JOURNAL OF SYPHILOGRAPHY AND DERMATOLOGY.

APRIL, 1870.

Original Communications.

ON THE PATHOLOGY OF ECZEMA.

BY FOSTER SWIFT, M.D.,

Professor of Dermatology in Bellevue Hospital Medical College.

OF all the forms of diseases of the skin that the general practitioner is called upon to treat, eczema, even in the restricted sense in which that term is more generally used, is by far the most common, and yet, notwithstanding its frequent occurrence, and in spite of the fact that its principal pathological lesion is superficial, we find the most various views of its pathology in authors of treatises on cutaneous disease. As the derivation of the word would indicate, from the Greek word *εκζεω*, to boil over, the ancients did not confine the term to any particular form of skin lesion, but included under it almost all the acute non-contagious eruptions, pustular, vesicular or what not. The same indefiniteness in the use of the term prevails in all the meagre literature of skin diseases of the middle ages, and in the more elaborate but still chaotic nomenclature of the last century down to the time of Willan, who, as is well known, attempted to systematize the knowledge of cutaneous disease, according to a classification based on the

¹ Read before the Medical Society of the County of New York, Feb. 21, 1870.

external lesion, a plan which, though in some cases, as in the one under consideration, has drawn attention away from the true nature of the disease, and, as M'Call Anderson says, has led to incalculable errors in diagnosis and treatment, still it must be recognized as the first attempt to cope with a most complicated subject, and the great proof of its value is, in the fact, that the influence of Willan's system is still generally felt at the end of eighty years. By Willan we find eczema placed among vesicular diseases of the skin, but soon it was found that there were cases of the disease, which though perhaps vesicular at its inception, soon acquired the peculiarities of either erythematous, papular or pustular eruptions, and it became necessary to create sub-classes to accommodate these cases, and we find forms described under the names of eczema lichenoides, erythematodes, impetiginodes and squamosum, Still it has only been within the last few years that eczema has been generally considered as anything else than a vesicular eruption, although it has been found necessary to qualify that definition. Thus, Devergie, in 1857, says that the disease is strictly vesicular, but that the development of the vesicles in some places is only momentary. More recent writers, as Wilson, in his later articles, admit that the elementary lesion is not necessarily a vesicle. But Hebra is decidedly the most prominent of those who have denied that any particular skin lesion is pathognomonic of eczema, but affirm that the disease is polymorphous in its effects on the skin. Hebra first published his views of this in 1862; but J. L. Milton, in an article in a recent number of the *Journal of Cutaneous Medicine*, lays claim to a priority in defining the more comprehensive view that is now held of the pathology of eczema. His paper on this subject was published in May, 1861. To Hebra, however, unquestionably belongs the distinction of definitely settling, by experiment, the point that eczema may appear either as an erythematous, vesicular, papular, pustular or scaly eruption. In his most recent publication on this subject, the letter-press accompanying Encke's Atlas, Hebra defines eczema, as he and other dermatologists consider it, as a disease characterized by the aggregation of papules or vesicles, or else as a more or less reddened surface, covered by thin scales, or as a reddened, moist

surface, covered by yellow, gummy, green or brown crusts—a disease non-contagious in its nature, and always accompanied by itching of an excessive degree. It is very evident, Hebra goes on to say, that from the above definition I make the term eczema more comprehensive than my predecessors and many of my contemporaries. In my opinion, it is not only *not* a form of disease that necessarily begins with the formation of vesicles and afterwards developing moist surfaces denuded of epithelium, but I regard all the diseased conditions that occur in the progress and retrogression of eczema, whatever their anatomical forms may be, as varieties of that disease, and I believe I am justified in that opinion by the following reasons: First, It is in our power to produce artificial eczemas by skin irritation, calling out in this way not only vesicles or moist surfaces, but causing, also, red desquamating surfaces, small pin-head papules or pustules. Secondly, We meet occasionally with cases of idiopathic, spontaneous eczema, affecting, perhaps, a great portion of the cutaneous surface, where, on one and the same patient, at the same time, we can find on some parts of the body scales on a red surface, or millet seed papules, on other parts vesicles, and on still others infiltrated patches of skin, covered by yellow, green or brown crusts. Thirdly, If a case of spontaneous eczema be carefully watched, it will be found to commence with the formation of vesicles of variable size, which either in part change into pustules, or burst and leave moist surfaces behind, or else the patch of eruption will be covered by yellow crusts, while the periphery of the patch exhibits either a papular eruption or a scaly surface. At the end of the diseased process, after the pustules have become confluent and have burst, and their contents dried into crusts, if these dry and fall off, red desquamating surfaces will be left behind, under which the derma will be found more or less infiltrated. Hebra corroborated these views by subjecting the skin to artificial irritation of various degrees of intensity, experimenting on different parts of the skin in the same individual, or the same parts of the skin in different individuals, with mixtures of croton oil of a fixed degree of strength, and he found that on rubbing in this solution various changes in the skin were produced, according to the part of the cutaneous surface irritated and the

susceptibility of the individual experimented upon. For instance, on the face and genitals an œdematous swelling would be produced, perhaps covered by transient vesicles which would burst immediately and leave behind a moist leeting surface, on the extremities papules, or pustules would be called out, according to the strength of the application of croton oil. If an irritation with a weaker solution were kept up for several days, other pathological changes would be induced, and as the inflammatory symptoms subsided, red desquamating surfaces, with infiltration of the derma, would be left behind. If the changes induced in the skin by artificial irritation be analyzed, it is apparent that they can be reduced to five groups corresponding to the sensitiveness of the part, the thickness of the epidermic covering, and the amount or degree of irritation. First, a condition of the skin will be induced resembling eczema squamosum. Secondly, an eczema papulatum, or as the Willanists call it, an eczema lichenoides. Thirdly, an eczema vesiculosum, the true type of Willan's eczema. Fourthly, an eczema rubrum or madidans, characterized by a red moist surface. And fifthly, an eczema pustulosum, which is the generally recognized eczema impetigenodes. It is evident then that according to the artificial classification of Willan we may with justice place eczema either among the erythematous, papular, vesicular, pustular or scaly eruptions, as we find forms of the disease, which present the peculiarities of these various groups of skin diseases. In fact, properly speaking, eczema is a dermatitis or inflammation of the skin of a mild type, and according to the degree of skin inflammation, or the thickness of the epidermic covering, we may have the same morbid entity expressed on the surface of the body by either an erythematous blush, a papule, a vesicle, a pustule, or a scale. Devergie was the first, I believe, to call attention to one elementary lesion as characterizing all forms and stages of eczematous inflammation, namely, a punctate injection of the skin, but this appearance is not pathognomonic of eczema alone; we find it in psoriasis, and in all forms of chronic skin disease, and its only significance is that it indicates a hyperæmic condition of the vascular net-work of the derma. In psoriasis the hyperæmia is relieved by increased physiological activity in the formation of

epidermic scales in an excessive degree, while in eczema the capillary congestion is more purely inflammatory, and passes through processes of a more purely inflammatory nature. So in fact we look in vain for any lesion visible to the naked eye which may be said to characterize the disease we are considering, and we must content ourselves with one which, although not characterizing eczema only, still is always present in that disease, namely, a congestion of the capillary net-work of the skin, as then there is no constant anatomical lesion which is visible to the naked eye that characterizes eczema, except the punctate injection of skin, which, as we have seen, is common to all forms of skin inflammation. On what are we to depend in the diagnosis of eczema? McCall Anderson, in his *resumé* of the disease, lays down four symptoms: 1st, infiltration of the skin; 2d, exudation on the surface of the skin; 3d, the formation of crusts; and 4th, itching. Of all these, the infiltration of the skin is by far the most important; it characterizes, however, more particularly the more protracted cases of eczema, and on it depend the other three symptoms. Itching, exudation and crusts; but in its turn it depends on the gorged condition of the capillary loops. It is to the vascular structure then that we must direct our attention in investigating the pathology of eczema, and I hope I may be pardoned in recalling a few general facts as to the anatomy of the skin, in order to lead to a more clear comprehension of the phenomena that have been observed in the microscopic study of the pathology of the disease we are considering. The skin is generally said to be composed of two structures, the derma and the epidermis; the first highly vascular, and richly supplied with nerves and lymphatics; the second nerveless, bloodless and lifeless. I think that this distinction of structures in the skin has led to unnecessary obscurity in the description of that organ; that it is unwarranted, and that it has led to the unwieldy classifications according to the external skin lesions that have so much embarrassed the progress of dermatology. The skin is in fact only one structure; its lower stratum is a fibro-elastic membrane, condensed from the areolar tissue that underlines it, and that connects the muscles with the skin and separates the groups of muscles; these fibres of areolar tissue at first loosely connected

and holding in the cavities, caused by their loose interlacement, masses of adipose tissue, become more and more condensed, until a homogeneous fibro-elastic structure results, permeated at frequent intervals by sudoriparous glands and hair follicles, and presenting an outer surface roughened everywhere by papillary projections of various size. The vascular supply of the skin penetrates this derma, breaking up into capillary loops, which are projected into the papillary form and surround the orifices of these glands and hair follicles. From this free, roughened surface of the derma a fluid is constantly exuded, which resembles serum closely, which is apparently homogeneous, and presents no organized form under microscopic examination at first, but soon free nuclei can be discovered, changing quickly into ovoid cells which are applied to each other in their longest diameter, as the cells of columnar epithelium are in mucous membranes; these cells rapidly increase in size, and as they are subjected to mutual pressure on their sides and to a constant pressure from the new cells forming below, they become more and more flattened from this pressure and from the drying up of their fluid contents, till they acquire a polyhedral shape, and are so exfoliated or thrown off from the free surface of the skin. So that in the cutaneous envelope we have an incessant growth—new cells developed from the fluid exuded from the rough surface of the derma, altering in shape as they develop in size, and sealing off from above. This process is constant, and the structure wherein these changes are going on—the cell—changes not in quality or kind, but in shape and development is called the epidermis, and is in fact nothing but accumulated and dried secretion of the living derma; the division into different layers—mucous and malpighian—referring in fact to the comparative youth of the cells, if I may use that expression. It is, however, more with the vascular supply of the skin than with any other element of its structure that we have to do. Of course we have a right to expect that this element should be particularly rich to permit of such a constant cell growth as we have indicated in the epidermis, as well as to supply the glandular and nervous functions of the skin with the requisite amount of blood. The arterial branches, as they reach the deepest portion of the

derma, subdivide and ultimately break up into a net-work of capillaries, from which loops are thrown up into the papillæ and surround the orifices of the glands and hair follicles, as we have already said. It is in these capillary loops that the marked changes characteristic of eczema occur. These capillaries, as described by Leydig, consist of a homogeneous transparent membrane, presenting at regular intervals round or oval nuclei, and so translucent and colorless, as in some cases to defy definition. That these translucent homogeneous tubes are capable of contraction and dilatation, the phenomena of blushing and pallor from mental emotion afford clear proof, and if their calibre is susceptible of such changes, a more permanent distension can take place there. Now, the most recent observation of what occurs in these capillaries during acute and chronic eczema are those given by Neumann, in his *HAND BOOK OF SKIN DISEASES*, published a few months ago. He says that the various symptoms of eczema show themselves on the skin of animals after the application of croton oil, just as in the human subject; he chose for his experiments the external ear of white rabbits, the inner surface of which presents no visible hairy growth. The oil was well rubbed in for ten or fifteen minutes, and then the ear subjected to examination with a working microscope, and the following phenomena observed: The most striking appearance at first was the rhythmical contraction and dilatation of the capillaries, which became fainter till the contraction finally ceased and stasis was established. When this occurred the portions of the ear examined began to grow more and more clouded, the arteries of the capillary vessels were lost, the tissues became more and more swelled and œdematous, and vesicles showed themselves on the surface, and when the animal was killed and that portion of the ear examined, it was found infiltrated with serum, with a marked proliferation of epidermic cells. Neumann personally did not pursue his investigations further than this, but he quotes the observations of Biesiadeski, as reported to the Royal Academy of Vienna in 1867, who describes the formation of papules and vesicles in eczema in the following manner. He says: The papillæ are broadened at their base and increased in length by being infiltrated with young cells and fluid blastema, closely

resembling serum, except in the fact, that from it cells are developed the connective tissue cells of the papillæ, become more prominent in size from fluid distension, and are also increased in number. In the lower stratum of the epidermis, in what is generally called the mucous layer, from the softness and ovoid form of the cells, numerous spindle-shaped cells are developed, which grow upward, pressing the cells of the epidermis apart, growing up into the horny or upper layer of the epidermic covering, and forming a net-work in which the somewhat swollen cells of the epidermis are embedded. This circumscribed elevation constituted a papule. If the new formation of spindle-shaped cells takes place more especially within the papillæ, and the young epithelial cells of the lower or mucous layer of the epidermis become distended with fluid and finally burst, then the outer epithelium is raised by this fluid and so an eczematous vesicle is formed. In vesicular eczema the spindle-shaped cells are present in still greater quantity, and lying in their long diameter and dipping deep into the structure of the papillæ, they serve as sap channels, as it were, and the fluid traverses through them to such an extent that finally the epidermic covering yields and the vesicle bursts. The fluid that leaks out through these channels does not differ from ordinary serum, presenting no organized forms under microscopic examination, and drying when exposed to the air into crusts of various colors. If the eczema is chronic the same process is continued, but the skin becomes thicker, the lines and furrows deeper, the papillæ so much more prominent as to be visible to the naked eye; in fact, what is called chronic infiltration of the skin results, a condition characterising all protracted eruptions, but more marked in eczema, and doubtless is due to the genesis and proliferation of the spindle-shaped cells above alluded to. Thus we see that the principal change observed in all cases of eczema has to do with the capillary loops primarily, and that although a new growth of these spindle-shaped cells occurs when the disease has existed a long time, this new development of cell growth succeeds a protracted condition of hyperæmia, or, in other words, a distended state of the capillaries. It is then, in this structure, that we must look for those changes that will enable us to classify

the forms of eezema, and if we will examine the disease in its totality we shall find, I think, that independent of any of the usually recognized pathological changes, independent of the vesicle, papule, pustule, or scale, we are able to recognize three different conditions of these capillary tubes, as they lie imbedded in the structure of the papillæ or surround with a net-work the orifices of the sudoriparous glands and hair follicles, which enables us to distinguish three different stages of eezema, and affords us therapeutical indications for the treatment of each case. In the first stage we have an active hyperæmia, dependent either on an internal or an external cause, in which the *vis a tergo* is the principal cause of the loaded condition of the capillaries. This active congestion may be the result of a purely external irritation, as a scald or burn, from a purely internal source of irritation, where it is the result, for instance, of a rheumatic or gouty diathesis, or, as is most common, having its predisposing cause in some constitutional diathesis, and being called out by a local irritation. This active hyperæmia or acute eezema, as it is called, is accompanied by a heat of skin, a sensation of itching or burning, and it is characterized by redness of the surface with a punctate injection that subsides under the pressure of the finger to be instantly reproduced when that pressure is removed. This condition is quickly followed, in most cases, by the formation of minute vesicles, principally at the orifices of the sudoriparous glands, which are markedly evanescent, as at these points the epithelial covering is very thin, and as these vesicles are prevented from much distension by the fact that a thin layer of epidermic cells is carried down into the epidermis, and determines the early rupture of the vesicle. Now, if the cause of the active hyperæmia of acute eezema be removed, whether internal or external, or both, the capillary loops recover from their temporary engorgement, and resume their natural conditions; but let us suppose, as is apt to be the case, that the cause that produced the active hyperæmia be reproduced or protracted, the result is that the walls of the capillary vessels lose their power of contractility and a permanently sluggish current flows through these vessels, and nature, in order to relieve this over-distension, or perhaps to fulfill an impeded physiolog-

ical process, allows fluid to be poured out which may raise the superjacent epithelium into a papule, vesicle or pustule, or dry into a scale, on a previously denuded surface, according to the degree of the hyperæmia or the particular portion of the cutaneous surface involved.

These two stages illustrate the types of active and passive hyperæmia of the capillary loops of the derma. The first due to increased heart action, attended, perhaps, with some constitutional disturbance, marked by heat and a vivid redness of the skin, the vessels refilling promptly when emptied by pressure of the finger; the second due to a relaxed condition of the blood vessels, attended with less heat of the skin, more itching, and a redness that, disappearing under pressure, reappears more slowly. Now, the third condition differs from the other two in the fact that, in addition to the condition of passive hyperæmia which exists in the second stage, just considered, we have another element added, in the shape of a mechanical impediment to the free return of blood from the derma. Let us imagine a certain portion of the skin subjected to frequent attacks of acute eczema, or else to a prolonged attack of that disease. What is the result? First, The capillary loses its resiliency—loses its power to return the blood by its own contraction—and nature, in order to relieve that prolonged engorged condition, allows the liquor sanguinis to exude, as we know it does, from a vesicated surface. This fibrinous exudation becomes organized into cells and fibres, or else the spindle-shaped cells become developed in great numbers, permeating the structure of the derma in every direction; that organ becomes thickened, loses its normal elasticity, and cracks when the subjacent muscles are moved, and that thickened, doughy condition of the skin is produced which is known as cutaneous infiltration, and which characterizes all cases of chronic eczema. This exudation and new cell growth becomes the real *materies morbi*. It presents, from its organization and contraction, a mechanical obstruction to the return of blood from the capillaries, which are now over-distended, not only from a want of contractility in their own walls, but from mechanical pressure outside those walls. Eczema, then, in this view, may be said to present itself under three forms, which are but stages in

the same process, independent of the usually recognized elementary lesions. The first stage is one of active hyperæmia; the second one of passive hyperæmia; the third one of mechanical hyperæmia; and I think the indications for the treatment of the disease are simplified by this view of the case. I shall not claim the valuable time of the members of the society by attempting to give a *resumé* of that complicated subject, the treatment of eczema, but will only say that as almost every case of the disease is dependent on an internal predisposing and an external direct cause, so the therapeutics arranges itself under two heads, the one in which the treatment is directed toward combatting the constitutional diathesis, the other, where by local means we endeavor to ward off external irritation, to restore tone to the distended capillary, or to promote the removal of any mechanical impediment to the free capillary circulation. It is needless for me to allude to the various remedies, with which every one is familiar, for combatting the diatheses which so frequently lie at the base of eczema. But there is one remedy used internally which is proverbially beneficial in this disease as in all chronic eruptious, namely, arsenic, and from its known use as a cosmetic, as well as its poisonous effects in producing local œdema, and especially congestion and inflammation of mucous surfaces, it seems fair to suppose that the good effects of this drug in chronic eruptious arise from its stimulating effects on the cutaneous capillary circulation, and from its vivifying the physiological function of that organ, and restoring tone to its vascular net-work. Vastly more important than the internal treatment of eczema, is the external. Apart from those forms of the disease which are of a parasitic origin (as eczema marginatum), we have in the remedies to be applied externally, baths, fluid and oleaginous applications included, therapeutic agents by which we can combat the itching of eczema, relieve an inflammatory congestion of the capillaries of the skin, restore tone to their over-distended walls, or promote the removal of the organized material that obstructs the free circulation of the blood. In treating acute eczema, our object after controlling, if possible, the constitutional diathesis that acts as the provocative cause, and relieving the local nervous irritation, by incorporating in

the application some nervous sedative, as opium, camphor or hydrocyanic acid, is either by applying lotions to procure the revulsive effects of cold, or else by sheathing the part in some mild oleaginous preparation, as the benzoated zinc ointment, cucumber ointment or Carron oil, to give a certain suppleness to the skin and to ward off the irritating effects of the air in drying any fluid exudation. In the second stage of eczema the grand object is by local agents to restore the tone of the capillary vessels, and, for this purpose, we have at our disposal two groups of medicines, especially—First, the astringents represented by the acetate of lead and tannin applied in ointments; and secondly, that very important class of pyroligneous compounds embracing the oil of eade, carbolic acid and all the tarry preparations. In treating the third degree of eczema which is characterized by a gorged condition of the capillaries and the deposit of adventitious material outside the walls of the blood vessels, and which acts as an impediment to the free circulation of the blood, a condition known by the thick doughy feel of the skin when a fold is pinched between the finger and the thumb—infiltration of the derma, as it is called. We should endeavor in selecting our external remedies to remove, if possible, by absorption, this thickened condition of the derma, and, for this purpose, we must rely on counter-irritants of various strength and form, such as blistering collodium, tincture of iodine, strong solutions of caustic potassæ, or the persistent and violent inunction of alkalies, as in the form of the green soap, suggested by Hebra, not forgetting to incorporate in our applications such agents as will relieve the itching of the skin, and the local tonics just alluded to, to restore tone to the distended capillary. My apology for going so superficially over the subject of the treatment of eczema is, that my only object has been to bring into stronger relief the divisions of eczema as indicated by the condition of the capillary vessels, and the therapeutic indications that they suggest.

OBSERVATIONS ON THE PAPULAR SYPHILIDES.

BY R. W. TAYLOR, M.D.,

Surgeon to the New York Dispensary—Department of Venereal and Skin Diseases.

It is not intended to present here a thoroughly systematic description of the papular form of syphilitic eruption; but, rather, to give the results of clinical study and a histological research into its varied phases of development and its peculiar modes of distribution, by reason of which facts, it sometimes presents striking resemblances to other diseases, rendering the diagnosis in some cases difficult. As the papular syphilide is, next to the macular, of most frequent occurrence, and as it seems much more prone than any other form of syphilitic lesion of the skin, to undergo various morphological changes, a clear knowledge of its history renders the study of the other syphilides much easier. There certainly is no syphilide, about which there have been so many discordant opinions, nor one that has been more variously named than the papular, and this discordance in opinion and variety of nomenclature are attributable wholly to two causes: first, a not sufficiently broad and clear definition of what lesion the word papule should represent; secondly, the fact that the papule in its evolution assumes certain forms of configuration by which it strikingly resembles other diseases of the skin.

It is of the utmost importance, then, to define concisely the limits of the term syphilitic papule in advance of a thorough study of its clinical history.

The word papule is a generic term applied to any solid elevation of the skin, whatever may be its cause, whether by deposit of new cells, or a hyperæmia around a follicle, or an enlargement of the *papillæ cutis*; that is, any elevation of the skin due to hyperæmia, and deposit into its uppermost layers. And this latter fact of the deposit being confined to the more superficial layers of the derma is of great importance

histologically, as it serves as a distinguishing feature between the papule and the tubercle, which latter, involving in the majority of cases both the uppermost and deepest layers of the derma, is, in itself, only an exaggerated papule. Now this distinction between papules and tubercles, particularly those of syphilis, is one easily made out histologically, but in clinical practice it is not so readily recognized, and hence authors, who describe these lesions wholly from a clinical stand-point, term a well-pronounced papule of large area a papulo-tubercle, a redundancy of nomenclature which is rendered unnecessary by the definition we have given, which includes elevations of the skin of minute and, in some cases, quite extensive area, provided the pathological changes which produce them are developed superficially in the derma. Furthermore, the well known laws of the evolution of syphilis add their support to our proposition; that is, as the disease manifests itself visibly upon the integument, either by a protracted and superficial hyperæmia, or a not very profound cell-infiltration, its course is usually, in later stages, to involve the deeper structure of tissues and organs. So that, basing our nomenclature upon the stages of syphilis, as shown by clinical observation and histological research, it seems very simple to reserve the terms, macular, papular, pustular and vesicular to the dermal lesions of the secondary period, and to apply the term tubercular, with any necessary explicative adjective, to the dermal lesions of the tertiary period.

All observers, however, are aware that this law of tegumentary manifestation is not unvarying; but that in some cases, deeper lesions, such as periostitis and iritis precede, by quite an interval, the exanthem, and also, that it is not possible, in every instance, to accurately determine whether a given case is in its secondary or tertiary period, as, for instance, I have now a patient under treatment for very deep and extensive ulceration of the throat, who has a single ring of papules near the left *ala nasi*, and another having ulcerating gummy tumors of the leg, who also has an extensive papular syphilide upon the forehead. But we draw our conclusions from generalities rather than from exceptions; therefore, to prevent repetition, the clinical history and pathology of the non-ulcerating syphil-

itic tubercle, which presents some resemblances to the syphilitic papule, will be considered in a future article in this journal.

As usually described in the text books, the papularsyphilide consists of two varieties, the miliary or conical papule of the size of the head of a large pin, and the lenticular or flat papule which may have an area of one or even two lines. This division is certainly, for general purposes, sufficient, but it admits, without any confusion, of further subdivision, as follows: Of the miliary or conical papule there are two distinct forms, the one being of the size of the head of a large pin, and the other having at its base an area of about one line; then, of the lenticular or flat variety, there is the small variety which has an area of one line, and there are intermediate sizes until it occupies an extent, in some instances, of nearly an inch. Though these elevations of the skin present to the eye varieties of configuration, they are all caused by the same pathological process. Now, when it is considered that mucous membranes are only slight modifications of the general tegumentary structure, it is readily seen that they may be the seat of the same lesions, produced by syphilis, as the skin itself, which is the fact, for when histologically studied *plaques muqueuses* have precisely the same pathological lesion as have the large and small papules, and their difference in appearance is due to the more lax and vascular structure of the membrane itself, and the conditions to which that membrane is subjected, by which these features are very soon destroyed. This fact proves the assertion made years ago by Cazenave,¹ who said that there was no elementary lesion of the skin, which could not be produced by the syphilitic virus, to which Bazin² replied, that the mucous patch had no analogue in dermatology. The researches of the German observers, who combined pathological knowledge with clinical study, have proved the correctness of the assertion of Cazenave.

The anatomical seat of the papule is principally in the *rete Malpighii*, and in the substance of the papillæ there may be

¹ *Traité des Syphilides, ou Maladies Vénériennes de la Peau.* Paris: 1843, page 206.

² *Leçons sur la Syphilis et les Syphilides.* Paris: 1866, page 224-5.

some very slight change in the reticular layer of the corium. In some cases there are evidences of the follicular origin of these tumors ; but this, contrary to the opinion of Zeissl,¹ who thinks all syphilitic papules have their origin in follicular congestion, with cell-infiltration, has been proved to be the exception rather than the rule. The morbid process consists in an active, local hyperæmia, which is soon followed by a copious proliferation of cells, which are generally small and ill-defined, somewhat granular, and some are nucleated, having a diameter of about 1-3,000th of an inch. They very much resemble the cells seen on a vertical section of an indurated ulcer, differ strikingly from the oval cells of the *rete Malpighii*, and belong to the class of granuloma of Virchow, which also includes gummy tumors, in which, however, the cells are larger, and more clearly defined, and also the elephantiasis Græcorum. These histological structures have already been so well described by Auspitz,² Virchow,³ Neumann,⁴ and can so readily be seen by excising a papule, and after proper preparation making vertical sections and examining them, that I consider further description needless. The chief factors then, in the epidermal elevation, which constitutes a papule, are, the cell infiltration, a swollen condition of the tissues of the *rete Malpighii* and of the papillæ, and a distended calibre of the vessels. It will be readily seen that the shape and external appearance of the papule are very much modified by the greater or less thickness of the super-imposed epidermis.

The small variety of the conical papule is probably less frequently met with than any of the other forms, but has a well marked history. The usual mode of evolution is by a general but discrete eruption, occurring principally upon the trunk, and sparsely upon the face and forehead ; and upon the back it shows a marked tendency to form round clusters or groups. This is mostly observed over and near the scapulæ. The papules are somewhat larger than the head of a large pin, and generally

¹ Lehrbuch der Constitutionellen Syphilis. Page 115.

² Ueber die Zellen Infiltration der Lederhaut. Medizinische Jahrbücher. Vol. 2, page 208, 1864.

³ Pathologie des Tumeurs (Trad. Fran.). Vol. 2, page 381, et seq.

⁴ Lehrbuch der Hautkrankheiten. Page 240.

remain several weeks before they disappear. This form is by some authors described as syphilitic lichen. There is a very interesting and not very common distribution of this papule which deserves careful description. Instead of appearing irregularly, the papules are developed in an elliptical or annular form, mostly observed upon the face and arms, less markedly so upon the trunk and legs. This is probably the only example of the first crop of a syphilitic eruption, which shows a tendency to the circular outline, a feature which is so constantly presented by relapsing secondary, and nearly all the tertiary eruptions. In consequence of its peculiar distribution it has been described by Wilson¹ as *lichen syphiliticus corymbosus*. Now, when these papules are viewed by the aid of a strong magnifying glass, it is seen that some are developed in the hair-follicles, others around the ducts of the sweat-follicles, while by far the greater number have not a follicular origin. In the circinate form, if they are watched from day to day, it will be seen that the papules gradually enlarge at their bases, still retaining their conical form, and finally coalesce and form a ring of about a line in breadth; then their papular features are wholly lost. While this process of coalescence has been going on, the enclosed area of skin, which is generally about half an inch in diameter, becomes markedly erythematous, and then, after a longer or shorter stationary period, the elevated ring begins slowly to sink down, the color becomes natural in the centre of the patch, and the ring, which was of a bright copper red, fades slightly. Coincidentally with these changes there is a quite free desquamation from the surface of the ring, the scales are small, flat, and slightly adherent, and consist merely of laminae of exfoliated epidermis. If, then, the term corymbous syphilitic lichen was applicable to the first stage of this eruption, certainly there are very striking features of resemblance between its later stage and a declining psoriasis, which resemblance increases as the eruption slowly disappears, and it would be equally as appropriate to call it then syphilitic psoriasis. The miliary papular syphilide, in rare cases, relapses in the shape of papules of only the size of the head of a small pin, which also assume a circular distribution. They

¹ Diseases of the Skin, Am. Ed., page 414.

are very slightly elevated above the level of the integument, gradually coalesce, and form rings of various sizes, from half an inch to an inch and a half in diameter. At their appearance the papules are usually closely set. Their color is never, even at first, a bright red, and they very soon have a decided coppery hue. Their most usual site is upon the face, around the mouth and upon the chin, and in the rarest of all cases on the arms. They, soon after their appearance, begin to desquamate, and the scales are extremely minute, flat, and thin. This variety runs a very chronic course, their salient stage lasts from one to two months, when they subside and leave dark copper-colored rings, which sometimes present a very unique, zebra-like appearance, which is very persistent, lasting even as long as six months. This appearance is sometimes rendered all the more remarkable by the development of small rings within larger ones. There is but one other circinate development of the miliary papule, which appears very late in the history of the disease, co-existing sometimes with tertiary lesions, and consists of a small papular ring, which is developed usually unsymmetrically, and in most cases near the labio-nasal furrow, or upon the face. It is necessary to remember that the vesicular syphilide in very rare cases appears upon the chin and near the lips in a circinate form, and, after the rupture or subsidence of the vesicles by absorption of their fluid, desquamates, and leaves the same persistent annular stainings as the miliary papules do. As has previously been stated, the miliary papule occurs as the first secondary eruption in a small number of cases, and is generally sparsely distributed over the body, with a tendency to form round groups near the scapular region. The papules last generally a month, and then subside and desquamate. Their desquamation is sometimes peculiar, as has been described by Bielt; the epidermis cracks around the margin of the papule sometime before it does in the centre, and a round collar of detached epidermis is seen. In other cases this feature is not observed, but the desquamation takes place from the whole surface of the papule in small scales. This is the syphilitic lichen of some authors.

Regarding the large miliary syphilitic papule, little need be said. It very rarely constitutes the whole eruption, generally

coexists with the small miliary or flat papular variety of syphilide, varies in color from a bright to a deep red, and is only peculiar from the fact that there is sometimes developed on the apex of the papule a minute pustule, and then is termed, by some authors,¹ pustulating syphilitic liehen. It is readily seen, however, that the elementary lesion was primarily a papule, and that the pustular element was merely an epiphenomenon. Finally, there is a condition of the ducts of the sudoriparous glands, which sometimes resemble very minute papules. When carefully viewed, they will be seen to be somewhat elevated and their orifices occluded by minute scales, and when the hand is passed over the integument a decidedly rough sensation is experienced. These little eminences can scarcely be called papules as they are not the result of cell-proliferation; they occur in cases of macular syphilide in which the hyperæmia has been much prolonged and very active, and they produce a free desquamation.

The small, flat or lenticular papule, is by far, the most frequent of any papular syphilide, and may occur either as a general eruption or as the first exanthem or as the first relapse. The shape of the papules of the early eruption is generally ovoid, and there may or may not be a number of round papules scattered irregularly over the body. Though the surface of these elevations is, as a rule, flat, there are some which are somewhat rounded. Their color varies very much from a light pink to a dark purple; an intermediate shade, however, is the rule. In the first rash or even exceptional cases of the first relapse there is no tendency to circular or ovoid distribution. It is not at all infrequent for this exanthem to coexist with a macular syphilide. In the first rash the distribution is pretty general over the whole body, upon the scalp, forehead and chin; very copious upon the back, showing a tendency to follow the obliquity of the ribs and to occur in clusters upon the scapula and upon the buttocks and on the margin of the gluteal furrow. Upon the anterior aspect of the trunk it is less copious, and it is very singular that, in by far the majority

¹ Skin Diseases, by Dr. Tilbury Fox, page 232. On Diseases of the Skin, by Erasmus Wilson (Am. Edition), page 474.

of cases, the *supra-* and *infra-clavicular* regions either wholly escape or are only very sparsely covered with the rash. Upon the arms it is generally not very copious, rarely seen on the back of the hand and never grouped there. Upon the palms it is sometimes very thick, and, though irregularly scattered, shows a tendency to develop upon the surface-furrows. When the eruption is general it always occurs upon the lower extremities, less copiously upon the thighs than upon the legs, and, in either case, more thickly upon the outer than inner aspect. When this eruption is thickly developed upon the face it always produces a very peculiar appearance, and, in some cases, materially alters the expression of the individual; but this is sometimes still more remarkable when the papules are very thickly and irregularly scattered over the forehead and chin, and when they are not at all pigmented, but look like small nodules of elevated, shiny integument. By the thickening of the skin its natural mobility is impaired and the whole aspect of the patient is changed. It is also remarkable that these papules may run their whole course without any hyperæmic appearances; in other cases they gradually assume a reddish color. This condition of the papules upon the face always coexists with pigmented papules elsewhere upon the body. In the aged, particularly in women, the altered facial expression is certainly indescribable. The duration of this form of papule is, of course, very materially influenced by treatment. I have seen cases in which, the patient having taken no medicine, the rash disappeared in four weeks, and in other similar cases it lasted ten weeks; generally it disappears very promptly under the influence of mercurials. As a rule, these papules disappear without leaving any other trace of their presence than a temporary pigmentation, but, in very rare cases, small cicatrices are left, which at first are of a decided coppery tint, and in time become depressed, white and shining. This phenomenon is mostly observed upon the face, particularly the forehead. The back of the neck from the base to the occiput very rarely escapes this rash, and upon this site there is a tendency to the development of much larger papules, particularly over the elevation of integument produced by the *vertebra prominens*, where the linen and coat collars

are closely applied, and chafe; here they sometimes attain an area of fully an inch.

In the first and subsequent relapses of the small flat papular syphilide, there is to be noticed a very decided tendency to assume circular or ovoid forms, and the rash is sparse as a rule, and shows sites of election. Upon the outer aspect of the arms, particularly from the elbow to the middle of the forearm, these papules have a decided tendency to be grouped either in the shape of rings or irregularly scattered. This latter condition is mostly observed upon the dense and rough integument over the *olecranon process*, while the rings are to be seen in the vicinity. This peculiar distribution, which is not at all infrequent, is very interesting in a diagnostic point of view, as the rings in the stationary period, and in the period of decline, resemble a declining psoriasis. Now, as the latter disease is so constantly found on this site, that its occurrence here is considered a diagnostic feature, the inexperienced might easily confound a peculiar form of syphilitic eruption with psoriasis. This error is all the more likely to occur when the relapsing syphilide appears late in the secondary period, and constitutes, as it often does, the only evidence of the activity of the virus. But the diagnosis can readily be made, as a history can generally be obtained of the primary appearance of small papules, which fuse and form circles, and in some cases large and small segments of circles, without any lesion of the enclosed integument. Though these circles desquamate, their scales are not imbricated, and are few and thin and not silvery, and scratching with the finger nail does not produce a bleeding surface as in psoriasis. This same peculiar distribution occurs near the anterior aspect of the knee, and along the neck, particularly on the border of the hairy scalp, and when it occurs it is not accompanied with many papules elsewhere upon the body. In some cases of late relapse of these papules, when they appear irregularly, but closely scattered upon the forearm, they resemble by their color and the glossy appearance of the epidermis which covers them, and by their angular outline, which is exceptionally seen, the papules of that rare form of dermatitis which Mr. Wilson¹ calls *lichen planus*, as both

¹ Journal of Cutaneous Medicine, No. 10, July, 1869.

varieties of papules have a chronic course, and leave melasmic markings, they are very liable to be confounded. The diagnosis, when carefully sought, is generally easy; *lichen planus* occurs most frequently upon the front of the forearm, has a tendency to aggregation, and there is hyperæmia between the papules; the papular syphilide occurs most constantly upon the outer aspect of the forearm, has no tendency to aggregation nor any inter-papular hyperæmia; the non-specific papule is not very appreciably elevated, while the specific papule is; the first in the majority of cases is attended with itching; the latter never itches, and has a history or traces of antecedent syphilitic phenomena.

The large lenticular papule may occur as the first general rash or as the relapse, and is always less copious than the smaller variety of flat papule. It is found upon the forehead and face, over the trunk and extremities. The papules vary very much in size, color, and elevation. As most generally found, they are about two lines in diameter, and are in the majority of cases oval; but in exceptional instances they attain a size of nearly an inch. It sometimes happens that about a dozen of this large variety co-exist irregularly scattered, with the general eruption of the small variety, and they are not at all infrequently met, as before stated, having attained a very large area and elevation over the region of the seventh cervical spinous process. The frequency of occurrence of this papule is not as great as that of the small flat variety, and it is greater than that of the miliary variety. Upon the face, particularly the cheeks from the *alæ nasi* to the malar process, this eruption is sometimes very copious, and has a peculiar tendency to coalesce and form irregular patches, which from their site, their coppery color, and the fact of a slight desquamation, and that the scales are small and quite adherent, might for the moment strike the observer as a case of *lupus erythematosus*. Also, upon the border of the scalp and forehead a line of these papules very often remains for some weeks. Upon the neck they are very frequently observed, and here they do not become very much elevated. There is only one site upon which this form of papule shows a tendency to the circular distribution, and this is on the palms of the hands

and soles of the feet. The papules are very slightly elevated, have a slightly deeper color than the normal integument, and a diameter generally of about half an inch. They may remain several weeks and disappear by subsidence and epidermal exfoliation, and it can be seen that on the sites which they occupied, there has been a loss of the uppermost layers of epithelium, and a minute detached fringe is observed around the circumference. There is a marked tendency to relapse in these situations, either circularly or irregularly grouped. These papules, when they reach a size of nearly an inch in diameter, are variously termed tubercles, papulo-tubercles, and mucous patches of the skin, but, as previously shown, they are allied to the other forms of papules by their histological structure and precocious development. There are very often noticed, coincident with a macular syphilide, elevated erythematous patches of the epidermis of a diameter of half an inch, the borders of which are not as sharply cut as those of the papules; they are termed by Bazin¹ *roséole papuleuse*; they are very often attended with a peculiar mode of desquamation described by Zeissl,² in which the uplifted epidermis peels off in laminae of equal size with the papule.

The subsidence of this, the large, form of papule is very often accomplished in a peculiar manner: the centre becomes depressed by absorption sooner than the periphery, and in very large papules, in which this peculiarity is most generally seen, there is an elevated and desquamating ovoid or ring which somewhat resembles a declining psoriasis. This large papule sometimes presents other phenomena, the epidermis covering it becomes exfoliated, and there is left a slightly granulated and moist surface, which may in very rare cases become covered with a species of false membrane; this is the *papule humide* of Bas-sereau and Zeissl. Again, when developed upon portions of integument which join mucous membranes, they constitute the *condylomata lata*, and upon mucous membranes the mucous patches. The lesion is the same in each case, and the differences of appearance are due to the varying structure of the

¹ Leçons sur la Syphilis et les Syphilides, page 282.

² Op. cit., page 114.

membrane upon which they are developed, and the external conditions to which they are subjected.

The involution of all varieties of syphilitic papules is accomplished principally by absorption and desquamation. The proliferated cells undergo fatty degeneration and are absorbed, the hyperæmia and swollen condition of the tissues of the papillæ and *rete Malpighii* subside, and generally but not invariably the process is somewhat expedited by desquamation. To recapitulate, the diseases with which the papular syphilides are most liable to be confounded are lichen and psoriasis. Between lichen and the small miliary papule the only element of resemblance is, that in the early stage of lichen there may be discovered small papules, all traces of which are soon lost, and dating from that stage the lesions become so totally dissimilar that no one could possibly confound them. In fact there can be no nomenclature more unscientific than this application of the generic term lichen, which was regarded by the older writers as the prototype of papular eruptions, to the small miliary papule, for, as has been previously demonstrated in this paper, this miliary papule, when it occurs in a circular form can at its declining stage be as properly termed a psoriasis as a lichen, because, the periphery of the patch desquamates, and the centre pales. There is a feature of resemblance between a declining psoriasis and the small lenticular papule, when that assumes a circular distribution, because the rings or segments of rings thus formed generally desquamate at their periphery, and enclose a centre of normal tissue ; this is all the more striking when this peculiar distribution occurs on the outer aspect of the elbow, a site where psoriasis is so constantly found. The cardinal point in the diagnosis of this and similar cases is, that when the papular syphilide is developed in an oval or circular manner, the centre of the patch is generally unaffected, and only in exceptional cases erythematous, whereas psoriasis begins as a small spot, which increases centrifugally, and afterwards heals in the centre, and the desquamation of the syphilide is generally slight, while that of the psoriasis is quite free.

The large lenticular papule may also present appearances resembling psoriasis. When the papules are not much elevated, and of a peculiar red color, and desquamate, they present anal-

agous features to the nummular spots of psoriasis ; also this is observed when they have attained a greater area and are much elevated, and on declining subside first at their centre. But their desquamation is generally totally different from that of psoriasis ; and from their uniformity of size, and from the fact that they show no tendency to increase beyond the limits of, at most, an inch, and are generally accompanied with other syphilitic phenomena, it is always easy to make a diagnosis ; so that the application of the word psoriasis, as being the prototype of scaling eruptions, to the various features and stages of the papular syphilide, is equally as unscientific as the use of the word lichen. Zeissl pertinently says, there can be no objection to the term scaling syphilide, as that expresses a declining form of the papular eruption. It is to be borne in mind, however, that the non-ulcerating tubercular syphilide is also attended, sometimes, with copious desquamation.

Finally, we may inquire whether there is a scaling syphilide. Reverting to histological results, we find, besides a cell-proliferation, hyperæmia in the tissues of the *rete Malpighii* and the papillæ, and there is every reason to suppose that, in consequence of the long-continued hyperæmia, there may be a proliferation of normal as well as abnormal cells. In fact, long-continued congestion of the integument, whether due to simple or specific causes, always results in increased epithelial cell growth. The desquamation of the syphilides, then, is an epiphenomenon rather than the essential lesion.

ON THE INDICATIONS FOR OPERATIVE INTERFERENCE IN CASES OF PHIMOSIS.

BY M. H. HENRY, M.D.,

Surgeon to the New York Dispensary :—Department of Venereal and Skin Diseases.

THE condition of the male genital organs known as phimosis, usually classed among the minor surgical diseases, so often becomes of serious importance that I think calling the attention of my readers to some features in the early and later treatment, will not prove uninteresting. Phimosis is usually regarded as simply a narrowed condition of the preputial orifice. The name, however, covers other conditions, such as redundancy of tissue or insufficient length of frænum. A partial phimosis is frequently met with in children, consisting of an unusually lengthy prepuce, which is generally so innocent of harm that no surgical interference is called for in infancy. This, however, may prove more serious in adult life ; which point I shall discuss further on.

While phimosis is regarded as that condition in which it is difficult or impossible to retract the prepuce behind the glans penis so as to lay it bare, paraphimosis is that condition where it is exceedingly difficult, if not impossible, to return the prepuce to cover the organ.

Where a paraphimosis has once occurred in the young, it is likely to occur again. The pain, fear and excitement of the first instance are soon forgotten by the little patient, and I believe the only prophylactic to be an operation. Where there is only unusual contraction, without any extraordinary amount of prepuce, I prefer simply to divide the prepuce on the dorsal aspect of the penis in the manner to be described. I am guided in the extent of the division according to circumstance, *i. e.*, the age and size of the patient, and the extent of the difficulty to be overcome.

"Cases of phimosis are referable to three heads: 1st, congenital; 2d, accidental or acquired; 3d, and not unfrequently, a combination of these two causes, as when some inflammatory disease has attacked the tissues of the prepuce or glans, and so either diminished the calibre of a naturally narrow orifice, or increased the dimensions of the contained part."¹

Phimosis often gradually develops itself independently of any pathological exciting cause, the explanation being, that, although in childhood the prepuce could be fully retracted, as the penis grows, the preputial orifice does not enlarge to a corresponding extent, so that after a time retraction cannot be accomplished. Among the many evils which may follow in the course of a phimosis are, the lodgement of any foreign body, such as bread crumbs, causing inflammation and ulceration within the preputial lining, and consequent adhesion, the formation of calculous concretions between the prepuce and glans; owing to the difficulty of micturition a portion of the urine is retained within the prepuce, dilating it after the manner of a pouch.²

Masturbation is often predisposed to by the irritation of retained smegma, calculous deposit, etc. Shortness of frænum may cause arcuation of the penis during erection, and predisposes to rupture of the frænum during coition, thereby adding to the danger of venereal infection. The following case well illustrates the dangers of venereal infection by persons suffering from phimosis.

In January, 1868, a gentleman consulted me for an obstinate gonnorrhœa which he had contracted some weeks before, and, to use his own words, "had failed to cure by the common methods," *i. e.*, injections of zinc and water. On examination I found an extremely offensive odor emitted, the prepuce unusually long and redundant, and in an extremely irritable and œdematous condition. With some difficulty the gonnorrhœa was cured, and the parts regained their normal appearances. Knowing the patient to be one of those young

¹ Holmes System of Surgery, Vol. IV., p. 640.

² These calculi have invariably been found to consist of the triple Phosphates.

gentlemen whose tastes and habits often lead them to venereal excesses, I suggested circumcision as a sanitary measure, and to lessen his chances of contracting any venereal disease in the future. The patient thought he would wait. In August of the same year (1868) I was again consulted by him, he at this time complaining of an extremely irritable condition of the parts, with painful erections, and a constant uneasy, smarting sensation about the penis.

There were some few herpetic vesicles on the glans, and some œdema of the prepuce. I again advised, and, in fact, insisted on, circumcision as the only treatment likely to afford a radical cure. With some hesitation he consented, and appointed the next day for the operation. During that afternoon, however, his dread of an operation, and hope that it might be averted, led him to the office of a well-known practitioner of this city, who promised a cure of his whole difficulty in a few days, and ridiculed the idea of circumcision, remarking, that only one or two men in New York would dream of such a measure.

I saw no more of the patient until the following April (1869), when I was again consulted. The patient had six weeks before contracted chaneres, there were four, situated on the prepuce, about three quarters of an inch from the orifice, and forming a cordon of ulcers; there was considerable swelling, thorough inability to retract the prepuce, and a strong tendency to sloughing, and altogether the parts bore an extremely ugly aspect. The patient had had enough of delay, and was prepared to do any thing I suggested. I performed circumcision, the portion removed embraced all the ulcers; the wound healed nicely, only a small portion remaining to unite by granulation. In nine days union was complete, and in twenty days the part had assumed a natural and healthy appearance.

Mr. Jonathan Hutchinson, the accomplished surgeon of the Metropolitan Free Hospital of London (situated in a locality in which many Jews reside), published, some years ago, an extremely interesting report "On the Influence of Circumcision in Preventing Syphilis."¹ He says: "My Jew patients have, I believe, been in proportion of nearly one-third to the others.

¹ Medical Times and Gazette, Dec. 1st, 1855.

The subjoined table shows the proportion of the two classes of venereal disease :

	Total of Venereal Cases.	Gonorrhœa.	Syphilis.	Proportion of Gonorrhœa to Syphilis.
Not Jews,	272	107	165	0·6 to 1
Jews,	58	47	11	4·3 to 1

“ Thus we find that, notwithstanding a gross proportion of nearly one-third to others, the cases of syphilis presented by Jews are only as one to fifteen. That this difference is not to be accounted for, either by their superior chastity or by their unwillingness to seek medical aid for such diseases, is conclusively proved by the fact that they furnish very nearly half the cases of gonorrhœa. The circumcised Jew is, then, very much less liable to contract syphilis than an uncircumcised person ;” and that “ it suggests itself as probable that circumcision was by Divine command made obligatory upon the Jews, not solely as a religious ordinance, but also with a view to the protection of health. . . . During the period from which the statistics just adduced have been obtained, I have had under care at the hospital a total of 262 children under the age of five years. Of these, 179 have been of Christian parentage, and 73 of Jewish. Among the former have occurred 27 cases of congenital syphilis, while among the latter there have been but three. Thus it would appear that but one-twenty-fourth of the surgical diseases of Jewish children acknowledge a syphilitic cause, while no less than one-sixth of those of Christians are of such origin. In this calculation I omit altogether the numerous diseases which are, in all probability, remotely dependent on syphilis, and comprise those only which present the disease in a well-marked form.” Mr. Hutchinson regards it the duty of the surgeon invariably to remove the prepuce of infants suffering from phimosis.

Reliquet¹ has met with instances of a general hysteriform condition, originating in the irritation associated with phimosis.

There is one feature of this portion of our subject, which I particularly desire to call attention to. Holmes, in his *System of Surgery*, speaks of atrophy of the glans, but I have

¹ *Traité des Operations des Voies Urinaires*, Paris, 1869.

been able to find in the literature of the subject scarcely any mention of an arrest of development of the entire penis, in consequence of neglected congenital phimosis. I have seen in my own practice three cases of this kind, in each of which, the patient, having arrived at adult age, presented a penis notably smaller than the ordinary size. This condition I conceive to be owing to the obstacle offered by the constricted and inextensible prepuce to the erectile function of the organ.

Epithelioma of the prepuce, though not of very frequent occurrence, is almost invariably found associated with a long and tight prepuce. It most commonly originates in the irritation produced by retention of the smegma, which induces the formation of an acrid purulent secretion, the growth of warty vegetations, and, in rapid sequence, epithelial cancer, which in this region is particularly rapid in its progress, speedily infecting the inguinal glands, and thus passing beyond the reach of our art. As a matter of course, circumcision is the only trustworthy prophylactic measure. Mr. Collis,¹ of Dublin, in speaking of this subject, says: "No warty growth on the prepuce should be neglected in any man of middle age."

Adhesions of the opposing surfaces of the prepuce and glans are often met with when there has existed much irritation and chronic inflammation.

Trousseau² has related cases of cure of incontinence of urine by circumcision.

Many symptoms simulating the presence of stone in the bladder are occasionally met with in children with a long and narrowed prepuce. I have had opportunities of relieving permanently sufferers from this distressing condition by circumcision.

Irritability of the urethra, sometimes extending to the bladder, at times follows unduly increased secretion of smegma from the elongated, and contracted preputial mucous membrane. Coulson³ cites the case of a boy seven years of age, who had for eight months complained of a frequent desire to make water, attended with difficulty in passing it, and pains

¹ On the Diagnosis and Treatment of Cancer and the Tumors analogous to it. By Maurice Henry Collis, London, 1864, p. 251.

² *Gaz. des Hôp.*, No. 9, 1860.

³ Diseases of the Bladder, 5th Edition, London, 1857.

around the lower part of the abdomen. On examination, the prepuce was found so contracted as scarcely to admit the point of a probe. The end of the prepuce was removed by circumcision. From that time the symptoms subsided, and the child recovered.

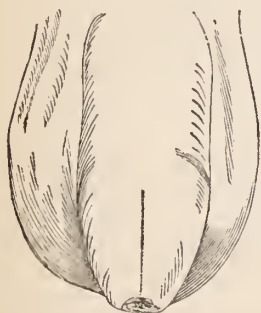
Herpes pro-genitalis, or preputialis, as it is often termed, although in part of constitutional origin, is often very readily excited in persons with a redundant prepuce, taking its rise either in uncleanness or in intercourse with an uncleanly woman. In some cases it becomes so severe as to lead to sloughing of the glans, and is always a troublesome affection. Phimosis not only plays an important part in engendering the disease, but also materially interferes with its proper treatment. I have met with several cases in which circumcision was required. In the case of a gentleman upon whom I performed the operation of circumcision about four years since, for a recurring herpes pro-genitalis, from which he had suffered at different times for a period of eight years, a radical cure was effected.

Prolapsus of the rectum in young children is not an uncommon accompaniment of phimosis, and any intestinal disturbance is apt to aggravate the preputial irritation.

The operative procedures for the cure of phimosis are various. The following are those in most general use by surgeons at the present time.

The operation of slitting up the prepuce in its dorsal portion is performed in various ways :

1st. With a pair of strong straight scissors, one blade of which, made probe-pointed, or flattened at the back, or guarded with a ball of wax, for the purpose, is passed upwards between the glans and the prepuce to the extent of the intended division, and the operation finished by closing the blades.



DORSAL INCISION.

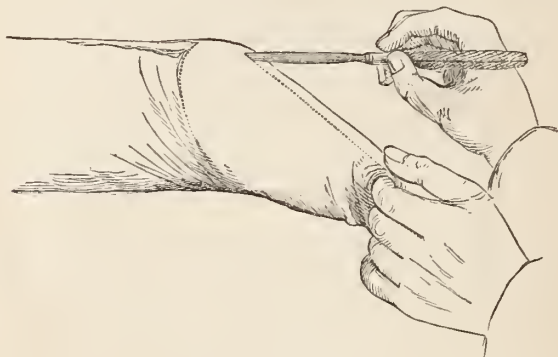
2d. The use of a narrow-bladed, sharp-pointed knife passed upwards between the glans and the prepuce, and made to transfix the prepuce, and then drawn forwards to the

drawn forwards to the orifice. In this method the point of the knife is sometimes guarded by a director, previously introduced, and sometimes the knife alone is used, its point being guarded with a ball of wax.

3d. For dorsal incision Reliquet mentions Blandin's bistoury with a retractable sheath. This would seem to be more complicated and less manageable than an ordinary bistoury guarded with a ball of wax.

No advantage, I think, is gained by the dorsal V incision as it is as much of an operation as circumcision, and does not give as good a result.

4th. My own method is to introduce a steel or silver director



THE AUTHOR'S METHOD.

with its groove filled with lead. Holding the director firmly between the forefinger and thumb of the left hand, the latter pressing upon and drawing down the prepuce, I enter the point of the knife from without, and engage it in the lead lining of of the director. Both instruments are then quickly withdrawn

together, and the incision is made. The advantages which, I think, may be claimed for this method are: 1st, that



THE AUTHOR'S LEAD-LINED DIRECTOR.

the point of transfixion can be more accurately made; 2d, that the skin and the mucous membrane are divided to an equal extent.

After dorsal incision it is customary to remove a triangular portion from each flap so as to leave a more sightly foreskin.

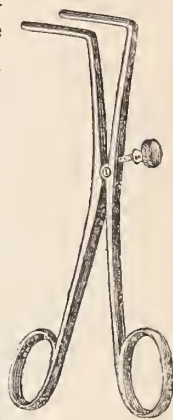
This, however, should not be done in cases where there are chancroids, as the probable contamination of the cut surface may lead to considerable loss of tissue.

Cruise, of Dublin, has recently advocated Nelaton's method of rupturing the preputial mucous membrane by sudden and forcible dilatation. He cites a number of cases which he regards as successfully treated in this way. He uses a pair of forceps with two blades at right angles with the handles. In Nelaton's forceps there are three blades as seen in the illustration. 'To enable the operator to regulate the extent of dilata-



NELATON'S FORCEPS.

tion, there is a little arc in the handles cut with a screw thread and carrying a moveable nut, which can be adjusted to the requirements of the case. Before operating the amount of dilatation required is calculated and the dilator adjusted accordingly. Cruise places a loop of thread round the penis, at the *corona glandis* to serve as a guide and measure, so that when the handles of the forceps are closed



CRUISE'S FORCEPS.

its blades separate enough to make this loop tense; he then seeks the preputial orifice where the skin and mucous membrane unite, inserts the closed blades of the forceps, (using care not to pass into the urethra); the handles are then closed suddenly and firmly, tearing the mucous membrane in the line of axis of the penis, so that the foreskin may be immediately and completely retracted. There is but little pain, and that only transitory. The only subsequent treatment required is the application of a strip of lint or linen moistened with water wrapped round the part to cover the wound, and retain the foreskin retracted. It is necessary to keep the foreskin retracted for twenty-four or forty-eight hours, as neglect of this precau-

¹ Dublin Quarterly Journal, November, 1869.

tion may lead to failure. About three years ago I operated on two patients in this way with an ordinary pair of dressing forceps, and the result was not satisfactory, in fact, no benefit was attained. I think, however, had I followed Dr. Cruise's precaution of keeping the foreskin retracted for a couple of days following the operation they might have been successful. I believe, however, this operation, while exceedingly severe, can only be of service in a very small number of cases, where the prepuce is only narrow at the orifice ; where there is any malformation, or great elongation, or redundancy of the part, I must confess I cannot conceive that any possible benefit can be derived, and the sooner circumcision is performed the sooner will the patient be freed from the pain and annoyance attending this condition of the parts. In cases of long standing irritation the orifice of the prepuce becomes fibrous and inextensible, which condition would, of course, contra-indicate the operation by dilatation. In this operation of forcible dilatation I would suggest that care be taken not to allow the prepuce to slip backwards over the glans before the operation is accomplished, otherwise the case might very easily be converted into one of paraphimosis. This may be prevented by embracing the glans tightly with the thumb, and index finger of the left hand as in the ordinary method employed for reducing a paraphimosis.

The main difficulty encountered in the operation of circumcision is the prevention of a retraction of the mucous membrane. There appears to be a "slipping away" or spasmodic drawing back of the mucous membrane whenever the skin of the prepuce is touched, altering the relative length of the two tissues, and, unless remedied by after incisions, seriously, at times, marring the success of an otherwise good operation. To overcome this difficulty many methods have been proposed by different surgeons. The operations are essentially the same, viz. : pulling the prepuce forward, grasping it firmly in front of the glans with a pair of strong clamp forceps in a line with the lateral obliquities of the *corona-glandis*, and removing that portion of the prepuce lying on the distal side of the forceps. Several expedients have been adopted for the purpose of insuring that the cut through the skin shall be at the same level with that through the mucous membrane. M. Ricord passes

a needle (its point previously guarded with a ball of wax)



RICORD'S METHOD.

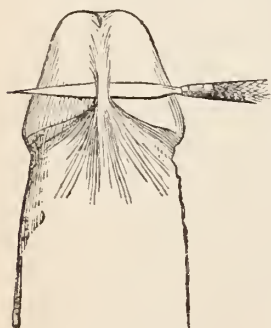
through the preputial orifice, then upward between the dorsal surface of the glans and the corresponding portion of the prepuce at a point on the upper aspect, a little anterior to the intended line of incision. Forward traction is then made

upon the needle, and the forceps applied behind it. A glance at the diagram will show that it is impracticable to pass the needle, in this way, evenly through the coats of the prepuce, but that the puncture of the skin will be posterior to that of the mucous membrane. My friend Dr. F. P. Foster suggests the introduction of a small grooved director beneath the prepuce up to the reflection of the mucous membrane; this being held in position with the left hand, a needle armed with stout silk is passed from above through the prepuce, and its point made to enter the groove of the director; the latter is then slowly withdrawn, and the needle made to follow it. Traction is then made on the loop of silk, and the forceps applied. This I think promises a more satisfactory result than the procedure of M. Ricord.

The forceps having been applied, the ablation may be effected either with a knife or with scissors. If a knife be used, the flattened and compressed prepuce should be transfixed close to the outer edge of the forceps, and the incision made outwards in either direction, as, if it be attempted to make the incision directly from one edge to the other, the knife is almost sure to slip and make a concave incision. My own habit is, to employ a pair of strong sharp scissors, either curved flatwise or straight, making a sure clean, cut. I prefer the curved scissors in operating on the adult, where the organ is more fully developed. It appears to me to follow the line of the glans more accurately. In children the straight scissors will answer every purpose.

In this operation I take no special pains to divide the skin and mucous membrane at the same level, but am content to curtail the mucous membrane subsequently with the scissors, if necessary. Grasping, in such case, the cut edges of the mucous membrane with a pair of ordinary thumb forceps, and drawing them forwards, I remove a sufficient portion of the membrane to allow of perfect coaptation after retraction. I then apply about eight points of interrupted suture of black silk, which, I think, is to be preferred to any other material or color, as it can be subsequently more readily recognized in the wound. I have several times employed the continued suture, but have abandoned its use, for the following reasons : any swelling coming on after the operation gives rise to more tension, and greater liability to ulceration ; and, should it be advisable to remove the suture at any one point, the whole is inevitably loosened. Sédillot advises that the prepuce should be compressed transversely by the clamp forceps ; this, I think, is not to be recommended, as the resulting border of the prepuce has a less natural and less desirable shape. After the operation the patient should for some days guard against the urine coming in contact with the wound. Union seldom occurs at once throughout the whole extent of the incision, but is usually complete in from four to six days.

In constriction of the preputial orifice, without redundancy of tissue, it has been recommended to make several notches in the margin of the prepuce. In my own experience the operation has proved unsatisfactory. I have been compelled subsequently to have recourse to a more thorough operation.



DIVISION OF FRÆNUM.

In cases of simple shortening of the frænum, division should be made by passing a knife with a straight narrow blade flatwise beneath the frænum, then directing the edge toward the frænum, and dividing it.

Many other symptoms than I have already described are, at times, met with, and due to the existence of a congenital phimosis ; such as balanitis, seminal emissions, imperfect and

painful ejaculation of the sperm, neuralgia, and general lassitude and prostration.

In conclusion, I would offer some suggestions regarding the conditions contra-indicating any operation. The presence of chancroids would as a general rule preclude the employment of any cutting operation ; still, cases may be met with in which the rule should be disregarded. Such as the existence of a sloughing or phagedenic sore. In cases of chancroid, where the prepuce becomes affected with hard œdema, the coaptation is so complete between it and the glans that any applications, such as injections, are rendered impracticable ; these are the cases in which perforation of the prepuce most frequently takes place.

In persons suffering under the hemorrhagic diathesis, the operation should be performed only as a last resort, and then care should be taken that necessary styptics, cautery irons, etc., be at hand. Even the actual cautery may fail to arrest hemorrhage from a mucous surface in persons suffering under this diathesis.

PROSTITUTION IN RELATION TO NATIONAL HEALTH.

LETTER FROM DR. W. BOECK,

Professor in the University of Christiania, Norway.

TO THE EDITOR OF THE WESTMINSTER REVIEW,—

SIR :—Your article on Prostitution, etc., in the Westminster Review, July, 1869, is of the greatest interest to society, and ought, therefore, to be attentively perused by all, but more especially by those who have thought on the matter, or made it an object of special study. To these last belongs the author of these lines, who has studied syphilitic affections nearly forty years, and made them a specialty for the last twenty.

When I take the liberty of making some remarks on your article, in which I shall frequently express views differing from your own, I beg of you not to misunderstand me. The praiseworthy intention of your paper has been to awaken the public to the spread of a fearful disease ; it is only on some points regarding the mode of its extension that we differ, and it is because I think it important that the public, as well as physicians, should be furnished with the best possible information, that I am induced to present the results of a long practice.

You repeatedly call our attention to the fact, that syphilis does not exhibit its fearful consequences only in the form of syphilis, but exerts its destructive powers on the whole system, and gives rise to many diseases in the different organs. It is a proposition that cannot be too often repeated, that the relapse of syphilis is of the smaller importance ; but when syphilis having been repressed—driven back, as it were, into the organ-

ism—shows itself in the form of paralysis, disease of liver or spleen, etc., we have to deal with it in its most terrible forms ; and these disorders, though of syphilitic origin, are the more often misunderstood, because in more populous places they do not come under the notice of the physician who treated the syphilitic disease in its more familiar forms. The physician who prescribed for a syphilitic subject ten years ago is not made aware that the same individual is now in charge of a colleague, laboring under paralysis.

The former has discharged the patient as cured by this or that means, and, perhaps, presents the case as a proof of the excellence of the remedy employed ; while the physician who treats the paralysis hears nothing of the previous attack of syphilis.

There is another point in which I agree entirely with you, viz., the ease with which syphilis is communicated, especially in the secondary forms from infants to nurses, and from nurses to infants and their surroundings. According to my experience, this communication is one of the most unfortunate events that can happen, whereby several families may be afflicted in a short period, especially in country districts, where it is the custom for every nursing woman to give the breast to any crying baby whose mother is not present. But if it be certain that infection is often caused in this manner, then it becomes the duty of the physician to see that syphilitic infants shall not be nursed by healthy women. This, however, was precisely what Dr. Price did.¹

I come next to the array of facts you present in support of the theory that the child may be infected through the medium of the milk. This I have never observed, and am quite indisposed to consider as proved. You cite (page 97) the case of a syphilitic woman, who, having a sore on one nipple, gave a strange child suck from that breast, reserving the other, free from sore, for her own, yet the latter became infected. By accident I had a similar case last year in the Christiania Hospital, with this difference, that the child nursing from the healthy breast did not contract syphilis. It is true that one positive fact

¹American Reprint, p. 97.

proves more than all possible negatives, but we may agree that a woman giving the breast to a child during the night may very easily make a mistake. There is one thing I must allow to be possible, although I have never seen such occurrence, namely, that a woman who has had syphilis and been healed, may in nursing get an excoriation on the nipple, and that a sore so arising may secrete a virulent matter capable of infecting the child. Therefore, I consider it wrong to permit any woman who has had constitutional syphilis to suckle an infant.

In all my practice I have endeavored to obtain certain information as to the mode in which syphilis has been communicated, and the result is, that having no faith in many of the stories commonly told to the physician, I have never failed to discover the open door—so to speak—by which the virus gained entrance. I am, therefore, entirely opposed to the opinions you advance (page 99) that the syphilitic poison can be absorbed without abrasion of the skin; for if the genital mucous membrane, where the virus may obtain a lodgement, is not herein included—I am bound by the results of my extended experience to consider the observations as incorrect. Nor should we forget that it is much less dishonorable to have been infected in such manner than by a *coitus impurus*.

Among the possibilities of infection you advance the opinion that a husband may infect his wife through the medium of the semen. I have never known of such an occurrence. It is not uncommon for a husband to throw the blame on an ancient syphilis; but, whenever I have shown him that I did not believe the story, I have never failed to elicit the truth. Nor are all women models of chastity, and let them tell what stories they please, some of them at least have very prosaically contracted syphilis in the ordinary manner. This is indeed a most important point; for on its determination in connection with the question of the father's giving the disease to the child, hangs the propriety of a man's marrying who has had syphilis; and the happiness of whole families depends on the decision.

I will now briefly present the conclusions at which I have arrived, as the result of my long practice and, to me, satisfactory observations. The first child or children of a woman who has

had constitutional syphilis *after puberty* will commonly be syphilitic. If the father has had constitutional syphilis the child may be born syphilitic, but this is the exception, not the rule. I am quite aware that these views are opposed to those most commonly expressed in the books, but they are nevertheless true to nature, and in my practice I have looked more to nature than to books. When, therefore, a man who has had constitutional syphilis asks me if he can with propriety marry, I always recommend him to do so, making him understand that his wife may bear him a syphilitic child ; but that this is the exception not the rule ; and I have never had occasion to regret the advice given.

You advance the opinion that the mother may be infected through the medium of a syphilitic fœtus. The books indeed say so, and it seems not improbable ; but Nature says, No. So, too, it is said that if the mother suckle her syphilitic child she may be thereby infected. Again, No ! She may give it the breast, but will not take syphilis from the child. This has already been taught by your countryman, Colles. Several satisfactory observations have also convinced me of the correctness of his views.

You seem to be of opinion that the syphilitic virus can be preserved for a length of time, and compare it with vaccine in that respect ; but such is not the fact. The syphilitic virus is very volatile, or at least unstable in its composition, and in a few days becomes inert, however carefully it may have been preserved. You also express the belief that if one drop of syphilitic matter be mixed with a tumblerful of water, the resulting fluid may be successfully used to inoculate the disease. Experiment would soon cause you to abandon such belief.

You also touch on the treatment of syphilis, expressing the opinion that mercury and iodide of potassium are good remedies. In the earlier part of your article you have fairly described the effects of syphilis, and yet hold fast to mercury, which was doubtless employed in all the cases quoted. I was also a warm friend to mercury until I knew better, but for the last eighteen years I have known better, and now never use it. This better is syphilization, which you deery without understanding it.

You speak of it as a prophylactic ; as such you are right in condemning it, not so as a curative method. I have now employed it in twelve hundred cases, and that with a success which would astonish you if you had been witness to it. I cannot on this occasion write in detail, but in the *Lancet* and *British Medical Journal* for 1865, and in *Dr. Henry's Journal of Syphilography and Dermatology*, New York, January, 1870, you will find my method fully described. You will also find that in the last discussion in our medical society,¹ a majority of those who took part in it, spoke in favor of syphilization. The minutes of this discussion have been translated, and sent to all the medical journals in London, but none have published them, probably because the result was not the simultaneous putting down of both myself and syphilization. It is but natural, however, that you should look without doubting eyes on my statements, while you give full credit to the erroneous statements of others if they tally with your own *a priori* conclusions. I would, therefore, suggest a conference with Dr. Jonathan Hutchinson, who last June investigated the subject of Syphilis in Norway. Ask him if you are justified in speaking of this method with contempt.

You have depended more on authorities than on your own positive knowledge. It is always unwise to lean too much on authorities, especially when new questions arise ;—so many reasons for opposition may be adduced, not always relevant to the subject, but aimed rather at the innovator.

Having spoken of the mercurial treatment, I will state my own views on that subject in a few words. We all know how speedily syphilitic phenomena are sometimes apparently dispelled by mercury ; but the question is, is this desirable ? Experience teaches us that, before long, syphilitic phenomena will present themselves on the skin or mucous membranes, and, driven thence, in the connective tissues of various organs, finally attacking the more important viscera. This series of phenomena you have yourself described, but not traced them to the use of mercury. This I do ; for syphilis resembles the acute exanthemata, in that it must follow a given course.

¹ The Medical Society in Christiania, Norway.

Hindered therein, it takes revenge in a fearful manner. The much-praised mercurial treatment, therefore, I consider as the worst and most destructive means we can employ against syphilis. It would be much better to leave it to itself, when it would strive to pass through its regular stages, though often unsuccessfully; and the so-called expectative method has presented us with a number of miserable results. In syphilization we follow nature, assisting her to go through the stages she desires to complete; and the immunity which results from repeated inoculation proves the correctness of the theory on which it is founded.

Now, a few words on prostitution. I am well acquainted with the arrangements in your country; they are as poor as possible—probably worse even than in Turkey. The liberty accorded is simply license—an abuse. Public women are allowed to go at large, spreading disease, and it is considered an invasion of personal liberty to exercise control over and examine these abandoned beings, till, when at length they can no longer perambulate the streets, they apply at a hospital to be received and treated. But what answer do they too often receive? “There is no room!” That is the answer which rich and powerful England makes to her wretched venereal patients, and then lets them go on infecting more unfortunates. They must live, you know! Suppose the tables were turned, and the regulations with regard to prostitution of continental Europe were only to be found in England—would she then submit to any such stupid inhumanity as this? Yet you patiently permit thousands of your seamen and others to be ruined by the syphilitic poison; for it is not enough that English respect for public morals—I would rather call it prudery—forbids the systematic examination of prostitutes, but when they have spread disease any charlatan may harmfully administer to the poor victims, the most powerful drugs, especially mercury, without any prudential restraint. I have had abundant opportunity of seeing the results of this system. I have now expressed my views freely, and I beg you will not regard any seemingly harsh expressions as intended to convey more than just criticism will admit of.

W. BOECK.

NEW YORK, *March*, 1870.

Selections from Foreign Journals.

ALBINISMUS AND NIGRISMUS.

BY DR. H. BEIGEL,

Physician to the London Metropolitan Free Hospital.

TRANSLATED FROM VIRCHOW'S ARCHIVES BY HORATIO GOMEZ, M. D.

SINCE I published my work¹ on "*Albinismus Partialis, Vitiligo* and *Nigrismus*," numerous cases, both in hospital and private practice, have fallen under my observation, which confirm the views enunciated in the above-mentioned treatise. In my opinion, partial albinismus, and its counterpart, nigrismus, are dependent upon deranged nervous action. Both can occur as a consequence of influences which operate either within or without the organism—typhus, Addison's disease, pressure, temperature, &c. Hence they often appear as an accompaniment to other diseases, and either disappear with the same, or remain behind after the exciting cause has already ceased to exist. They can then undergo many changes, or remain permanent. Why the same exciting cause at one time produces increase of pigment (nigrismus), at another time, want of pigment (albinismus), cannot be explained. The fact itself is incontestably so; the most frequent event is the co-existence of both pigment anomalies in the same individual. The following case, to which Professor J. Russell Reynolds, in his division of the University College Hospital, had the kindness to call my attention, is of the greatest interest:

William Hill, carpenter, 26 years old, suffers from well-pro-nounced general progressive muscular atrophy. In his sixteenth year, hair showed itself in the pubic region; but on the right side most of it was of a whitish, on the left of a brownish color. The underlying skin, however, was in every respect in a normal condition. By degrees the white color assumed greater dimensions, until at length all the hair growing on the

¹ *Nova Acta Academiae Curiosorum.* Dresden: 1864. Vol. xxvi.

right side was involved in the change of color. Also, in the occipital region, according to the patient, there was a tuft of white hair, which afterwards changed to black. The complexion of the patient is delicate, but the skin of the private parts, whereon the white hair grew, is distinguished by nothing different from the remaining covering of the body. The disease from which the patient suffers began four years ago, at which time he, as a soldier, was very much exposed to damp. At first he experienced extraordinarily acute pains, and, after a lapse of time, he noticed his breast and back had assumed a marbled appearance, and bore, in many places, large dark spots. After a while the marbled condition disappeared, and, on examination, I find on the breast and back only large spots of partial nigrismus grouped together. The largest of these spots measures ten centimètres in diameter. The color is not exactly black, but still rather dark brown. Pityriasis is not present. The great interest of this case lies in the existence of a strip of partial albinismus, which extends over the abdomen, and is about two fingers in breadth. This strip is distinctly seen when the patient lies in bed. In the sitting position this strip is enclosed within the folds which are formed by the skin covering the abdominal walls. The patient says that for weeks together he could not maintain the horizontal position without suffering the greatest agony, and that he was therefore compelled for many weeks, day and night, to preserve the sitting posture. It was during this time that the white spot arose, and there is not the least doubt but that it was due to the friction of the long juxtaposition of the folds of skin over the abdomen. The patient's beard and moustache are of a yellow color, the hair of the head dark brown, also the eyelashes, the outer half of which is of a brighter hue than the inner. No member of the patient's family has been affected in a similar manner. From the circumstance that partial albinismus, at an earlier period in the patient's life, at which time he was entirely well, occurred without any special cause, I incline to the opinion that it was caused by a predisposition to a nervous affection, which has continued, until the patient has been exposed to unfavorable influences, which of themselves, perhaps, were only capable of producing rheumatism, if the nervous irritability had not at the same time existed. In the *rete mucosum* of the entire cutaneous covering there seemed to exist for a long time an abnormal activity, which showed itself in the appearance of dark spots, the seat and form of which changed in a marked manner. Nervous affections are pecu-

liarily liable to reflect themselves, not only in the nervous centres, but also in the peripheral terminations.

Eruptions of the most varied kinds are very frequently found in diseases of the nervous system, and epileptics with a healthy skin are most decidedly the exception. At least such was the case with several hundred hospital patients whom I have examined. *Albinismus*, *nigrismus*, *psoriasis*, *herpes*, *acute acne*, were daily occurrences; and, if a distinct form of skin disease were wanting, at least the skin itself was rough and in an unusual condition. Pigment anomalies can, as is known, be more frequently and distinctly seen on those parts of the body, which in their normal condition are distinguished by a greater amount of pigment, as the region of the nipples, scrotum, the orifice of the anus, etc. This circumstance caused me to examine another portion of the body in nervous diseases, which under healthy conditions, so to speak, affords a receptacle for pigment cells, I mean the fundus of the eye, by which it has already been demonstrated by ophthalmologists, that inflammatory antecedents from other intraocular pathological processes interfere with the normal distribution of pigment. The ophthalmoscopic examination of a considerable number of patients, has proved to me that increase of pigment (*nigrismus*) in the fundus of the eye of patients of different kinds is not at all rare.

Among epileptics and individuals who have long suffered from vertigo and other affections of the central nervous system, total *nigrismus* of the fundus of the eye is relatively frequent. The entire fundus appears of a dark color, and the vessels can only be distinctly recognized when they are followed out from the optic nerve, which latter, in a remarkably beautiful manner, rises from its dark bed. The appearance may be likened to the black heavens, lighted up by the rising moon. Although I, as already observed, have comparatively frequently observed the accumulation of pigment in the eyes of nervous patients, I have never witnessed *albinismus* itself in a normal eye. In diseases, which, by and for themselves, involve pigment anomalies, a similar alteration in the color of the eye can be predicted. In *icterus*, for example, the pigment cells can be better seen by means of the ophthalmoscope, than is possible in the normal eye. Also, partial *nigrismus* of the fundus of the eye occurs in this disease. With negroes every form of deficiency of pigment must appear more striking than with Europeans, in whom the arising contrast cannot be so marked. Partial *albinismus* was, therefore, first observed among blacks, and many authors have, up to the most recent times, denied the occurrence of partial deficiency

of pigment in Europeans. The so-called Elstic negroes have been described in manifold ways, but a representation of the same, I do not recollect anywhere to have met with. I am indebted for a photograph to the kindness of the Rev. J. G. Wood, editor of Routledge's "Natural History of Man." The description of the individual in question is found in a book of travels by Captain Burton.¹ "Before a hut at Accra," says the author, "sat a singular being, a checkered man, as he would be described in ethnological and dermatological works." The greater portion of his skin was of a dirty white appearance, the rest consisted of a succession of dark colored spots. A few years before, the man was a negro, but gradually changed into a white one, and when we saw him the rete mucosum seemed again returning to its normal state. Besides the important extent of the discoloration in this individual, the symmetry, with which the change of color took place, is still of interest. The middle of the forehead and nose, right and left cheek, both ankles, the last phalanges of both feet, the breast and also the hair of the head are white, while both shoulders remained black. From different books of travels, which speak of Albinoes among blacks, the opinion seems to prevail, that albinismus in many families is hereditary, so that the greater portion of those who show the abnormality are miserable, sickly subjects. We refer to the case reported by Boyle at Borneo² of a native whose skin had an unhealthy dirty white color, which was interspersed with large freckle-like spots. The color of the hair could hardly be described, the eyes on the contrary were of a pale blue; he was unable to gaze with them, as he was blinded by a full flood of sunlight, consequently he could not see well until the sun was low in the horizon. He looked undoubtedly like a white, and the Dyaks of Magis Malipa cracked their jokes with him. The affection, according to Boyle, is not rare at Borneo. The parents of the individual just described have the national complexion, on the other hand all his brothers and sisters are Albinoes. Also, many of his ancestors are said to have borne the same discoloration.

In conclusion, I would point out another pigment anomaly among negroes, which I have never before found described, and which I for the first time met with in the book of Captain Burton³ already alluded to. This writer describes the anomaly

¹ Wanderings in West Africa, from Liverpool to Fernando Po, by a F. R. C. S., London, 1863, Vol. II. page 156.

² Fredrick Boyle's Adventures Among the Dyaks of Borneo, London, 1865, page 96.

³ *Ibid.*, p. 176.

very appropriately, as semi-albinismus, by which he desires to describe a condition of skin color which stands between the natural hue of blacks and whites. General albinismus is, to a certain degree (only half, with reference to its intensity), developed, and then makes no further progress. Semi-albinismus is, consequently, among negroes, with regard to the intensity of the color of the skin, what partial albinismus signifies with reference to its extension, with negroes as well as whites.

In Aëra, says Burton, I saw a second anthropological curiosity. Albinoes have, indeed, been seen by every African traveller, but not semi-Albinoes. My specimen was a man with the decided face and cranial formation peculiar to our "poor black brethren." His complexion was *café au lait*, the hair dull yellow, but short and woolly, as belongs to his race. The color of the eyes was of a lively brown. Since then I have seen many such individuals in Borneo, one of whom was the chief Shandy at Botanga.

Here follow the divisions of pigment anomalies :

I. Want of pigment (*albinismus*).

1. Total albinismus.
2. Partial albinismus—both to be met with in negroes and Europeans.
3. Semi-albinismus—only observed in negroes.

II. Increase of pigment (*nigrismus*).

1. Total nigrismus.
2. Partial nigrismus—both of which can only be seen among whites and half-whites.

AREA CELSI: A HISTOLOGICAL INVESTIGATION.

BY PROF. RINDFLEISCH,

OF BONN.

TRANSLATED FROM ARCHIV FÜR DERMATOLOGIE U. SYPHILIS, BY DR.
FRANK P. FOSTER.

THAT circumscribed form of *alopecia*, which Willan named *porrigo decalvans*, and Cazenave, *vitiligo*, and which v. Bärensprung has depicted under the name of *area Celsi*, is not a parasitic disease, but a disorder of the formation of the hair, wholly independent of any parasitic growth. The striking similarity which its invasion and mode of extension offer with

the invasion and mode of extension of *herpes tonsurans*, an undoubtedly parasitic disease, may easily have brought it about, that a statement of Gruby's, manifestly resting on a mistake, and which specified the parasite of *area Celsi* (the *microsporon Audouini*), should have held its ground for twenty years, and all along have found some adherents. It certainly may now be looked upon as a thoroughly exploded view, as a myth (*Pincus*), and it is not my present purpose to ventilate anew this, for me, already decided question. I avail myself rather of the negative positions of all the most recent authors, for whose names and doings I beg to refer to Pincus (*Deutsche Klinik*, January, 1869) and Boeck (*Virchow's Archiv*, xliii, 336), and ask: If *area Celsi* is not a parasitic disease, what is it? Let the falling out of the hair be interpreted with the aid of the microscope in any other manner, and in this case what conclusion does such interpretation allow us in regard to the nature of the malady?

First of all let it be set down, that the falling out of the hair in *area Celsi* certainly first shows itself markedly in one or in isolated points, and only in these proceeds to perfect baldness, but that at the same time the hairs seem everywhere more loosely implanted, and come out in unwonted number on using the comb. If these hairs removed at combing or by proportionately insignificant traction be examined, they will be found to be well formed in every particular, only that the bulb is wanting. The radical end is cut off squarely or oftener obliquely, and the substance of the hair itself so closely infiltrated with very small fat-granules (?) [Fett (?) Körnchen], that it appears white by direct, and almost black by transmitted light. Accordingly, that in the very act of falling out there is accomplished a solution of continuity, which is predisposed to by the infiltration with fine, dust-like, black granules, and consummated by the slight pulling with the comb, is a very obvious presumption, and one which is abundantly confirmed by further investigation.

We proceed now to the consideration of the *still firmly implanted hair*, and of the *bald portion of the scalp*. The pale, bloodless, and at the same time slightly nodulated condition of the latter is prominently set forth by authors. I agree to this statement, and add to it, that this nodular appearance depends principally on a certainly only apparent enlargement of the hair follicles and sebaceous glands. The surrounding skin has lost its *turgor*. Therefore, the hair follicles, if they have not lost their *turgor*, as in this case they have not, must give rise to corresponding protuberances on the surface of the skin.

If we search for the stumps of the hairs that have fallen out or been broken off, we shall notice, contrary to what happens in *herpes tonsurans*, where most of them project from one-and-a-half to two lines from the hair follicles, scarcely here and there a little stump, which moreover can easily be brushed away, and is manifestly no longer connected with its hair papilla. We can here only draw the conclusion that the locality of the solution of continuity is not, as in *herpes tonsurans*, above the level of the skin, but in the hair follicle itself. We now seek this out, and pull forcibly at the end of one of the hairs at the immediate border of the bald spot. The resistance which we find in the extraction is less than in that of an equally strong normal hair; yet, as a rule, it is not the hair alone that comes out, but with it both the coverings of the root, from the mouths of the sebaceous follicles hard on to the fundus of the hair follicle. This is a most interesting point, which farther on will occupy us more fully.

This is always striking, and can be due only to an abnormal relation of the hair to the root-sheath, since the latter clings fast to the extracted hair. In our cases, only the middle part has adhered, but we could plainly perceive upon it the outer layer corresponding to the rete Malpighii, and the inner to the hair lamella. Various suppositions might be suggested. It might be thought that the root-sheaths rested unusually loosely upon the areolar wall of the hair follicle, that perhaps a catarrhal secretion intervened. Yet this is contradicted by the normal appearance of every portion of the outermost layer of cells. Should there be present a recognizable catarrh, there would surely be no lack of young cells, pus-corpuscles, etc. Moreover, we know that catarrh of the hair follicles shows itself under an altogether different anatomical form (*acne*). In the second place, we might bethink ourselves of a less energetic pathological new formation—a hyperplasia of the root-sheaths, and fancy that by the agency of this hyperplasia in the given space so powerful a centripetal pressure should be brought to bear upon the hair, that a separation of the root-sheaths from the hair follicle might more easily happen than a loosening of the latter from the closely embraced surface of the hair. A glance at the hair, observing that, just beneath the part pressed upon, that point where we are to look for the future solution of continuity is to be seen, in the form of an obscurely granular zone upon the shaft of the hair, inclines us to consider the whole process as probably dependent upon this influence of the hyperplastic root-sheath in crowding the hair, and interfering with its growth and nutrition. But we do not wish to be pre-

capitate, but to examine carefully, and lo, the first step shows us that we are on a false path. Is the root-sheath, then, really in a state of hyperplasia? No, it is not; comparative enumerations show, that the number of layers of cells is here the same as in healthy hairs; and, besides, we know, that hyperplastic conditions in the root-sheaths of the hair are wont to show themselves under wholly different anatomical forms (*comedones, sycosis*, etc.). If, then, there be perceptible here no undeniable anomaly in the hold of the surface of the hair on the root-sheath, this—and this is the third possibility—can be owing only to the fact that for some time there has been a failure of the force which, overcoming the temporary pressure of the root-sheaths, should keep the hair loose and moveable. This force, as is well known, lies in the vigorous growth of the hair. Normal hair will continually and with irresistible energy push itself on to the surface of the root-sheath. That this goes on not without hindrance, and under press of considerable opposition, is taught by the familiar appearance of the cramping of the cells of the outer covering of the hair during its progress, especially through the middle region of the hair-sac between the fundus and the mouths of the sebaceous follicles. What wonder, if now, with a diminished force of growth, with a sort of stand-still of the growth of the hair, the hair should, just at this point particularly, be held fast, and form a sort of adhesion to the inside of the root-sheath?

Thus, without having as yet given any attention to the diseased hair-shaft itself, we have arrived at the generally received, and, in my opinion, the only correct view, that *area Celsi* has its origin in a diminished nutrition, a diminished growth of the hair.

The hair has become loose at its departure from its papilla, and now permits the place where the solution of continuity is afterwards to follow, to be plainly recognized and determined. This corresponds nearly to the limit of the lower and middle thirds of the proper hair-pouch, *i. e.*, of the follicle, extending from the fundus to the mouths of the sebaceous glands. Here is found, as already mentioned, that rather broad zone, of very dusky, almost black, appearance, which is occasioned by the accumulation of numberless little masses of fat in the substance of the hair-shaft. This is (1) the point, up to which the normal hair has reached its proper strength and hardness, *beyond which* it must be regarded as in a condition needing less nutrition, as having entered on a lower grade of life, but *previous to which* as still unfinished, growing, and in need of

nutrition. It is (2) the point above which the root-sheaths lie closely against the hair-shaft, and offer to its advance that relatively considerable resistance, which is overcome only by the normal energy of growth. Let us now assume that the energy of growth of the hair is in abeyance, *i. e.*, that the hair papilla produces in a given length of time fewer hair cells than under normal conditions, and let us seek, with this assumption, to explain the anatomical condition and the falling out of the hair.

The first effect of the diminished energy of growth of the hair must be the detention of the hair in the narrow part of the root-sheath. The extra-follicular portion of the hair no longer increases in length; young hair-cells are indeed continually furnished by the papilla, but the growth-pressure thereby produced is not sufficient to push the hair forwards in the direction of its length. If this is so, where do these hair-cells remain; what becomes of them, where do they find a place?

The answer to this second question lies in a knot-like swelling between the hair-bulb on the one hand, and the constriction of the hair follicle on the other. This knot-like swelling is indeed not altogether constant, but it is wanting in not more than one case in ten. It consists of tender, evidently yet unfinished, half-hardened cells, on which we can very readily recognize the three layers of the hair-shaft—cortex, body, and medulla. The medulla I have repeatedly found bent to a zig-zag, as if pushed together endwise. The swelling is possible only when the hair follicle is proportionately wide at this point, and the hair-substance still plastic. It should not be confounded with the always present bulging over the papilla, the normal bulb of the hair, which it often so closely encroaches upon, that the two are separated only by a slight groove. It might be called a false or supplementary bulb. Its real office is, to pack in a small space all those young hair-cells, which, with free egress through the hair-sac, would have formed a shaft of hair three or four times as long, although very much more slender. The irregularity thus produced in the growth of the hair, a sort of hypertrophy of the more recently formed, as yet unhardened, end of the hair, together with absolute inaction in the finished hair, finds its natural termination in the separation of the former from the latter. The mode of this separation is by a fatty degeneration of the hair-cells at the seat of junction of the two (*vide supra*). If this have proceeded to a certain extent, a slight dragging with the comb is sufficient to draw the free distal portion out of the hair follicle. Concerning the way in which the disturbance of nutrition, of

which we have to regard the fatty metamorphosis as the expression, is brought about just at this point, I can at present offer only a conjecture. That the whole hair, so long as it remains in connection with the organism, is in need of nutrition, I will not precisely deny ; the turning white of the hair indeed can scarcely be traced to anything else than a disturbance of this common nutrition. But if, on the one hand, this must be admitted, so, on the other hand, it may be as decidedly insisted upon, that the hair may divided into an outer segment less in need of nutrition, and into an inner one vastly more in need of it. The one will, according to our experience, be able to maintain its form unaltered under diminished nutrition, and show no further marks of the disturbance, while the other suffers, and the structural marks of its suffering appear most decidedly in those cells which are farthest from the nutrient papilla. Accordingly, it would certainly be the boundary-cells of the soft and hard, of the inner and outer, segments of the hair-shaft, which would run the greatest risk of being damaged, and thus the appearance of a solution of continuity, at the first glance somewhat surprising, would find its natural explanation.

So much in regard to the diseased condition of the hair, and the piliparous apparatus in *area Celsi*. At this stage I cannot forbear to inquire into the rational treatment of the disease. Two indications are to be fulfilled ; in the first place the attempt should be made to exalt the nutrition of the hair, and in the second place the opposition, which the hair encounters in its passage through the narrow portion of the follicle, must be reduced. A combination of equal parts of tincture of capsicum and glycerine has rendered me good service. After nine days the firmly implanted hairs could be removed without the root-sheaths, adhering ; and in them, instead of the supplementary bulb, an exceedingly slender, lengthened hair could be recognized, which fact shows that I was right in considering the secondary bulb as a false hypertrophy. Now, it is plainly to be seen, that there is here not a too thick, but a much too thin, hair formed, which, only for the impediment to extension, would have assumed a short and thick form. The black portion is pushed upwards, and may, at a rough calculation, be found at the level of the mouths of the sebaceous follicles. Now, I think that the glycerine renders the narrow portion of the hair-sac more distensible, and breaks up the adhesion of the hair to the root-sheaths, thereby fulfilling the second of our indications. I have employed the tincture of capsicum as a mild rubefacient, as such it has done its duty, and, sooner than I had expected, the bald spots have become clothed with

the well-known downy hairs. Further experience indeed must determine whether the pigmentation of the hair, also the formation of new pigmented hairs, proceeds more rapidly than before ; in regard to which I can as yet say nothing.

In conclusion I will remark, that in one of my cases a severe chilling of the scalp was stoutly maintained to be the cause of the disease. The patient had ascended a mountain, and on the peak of the mountain had uncovered his head, which was sweating profusely, at the same time that a strong wind was blowing. On the following night he complained to his bed-fellow, that he felt as if his scalp were crumpled up. Shortly afterwards the falling of the hair took place (*Trophoneurosis* ?)

ON A PECULIAR NEW FORMATION ABOUT THE NOSE : RHINOSCLEROMA.

BY PROFESSOR HEBRA.

WITH HISTOLOGICAL EXAMINATION BY DR. MORIZ KOHN.

TRANSLATED FROM WIENER MEDIZINISCHE WOCHENSCHRIFT JANUARY, 1870.
BY DR. EDWARD FRANKEL.

IN the course of several years I have had occasion to observe a skin disease in nine individuals (four men, five women), which, by having its seat either on the nose or in its immediate vicinity, as also by the peculiarity of its phenomena, presented itself as a malady *sui generis*. To form an idea of it, a substantial syphilitic sclerosis of the prepuce, *in optima forma*, may in imagination be transplanted to the external nasal structures, in one case even to the alæ nasi, and in another to the nasal ridge ; to the mucous surfaces which form the borders of the nasal cavity ; or, lastly, to the skin of the parts surrounding the nose, as the upper lip, skin, forehead. Among the nine observed cases there were only two which presented the disease on the nose, cheek, and forehead simultaneously ; in the others it was confined to the nose and upper lip alone. As a flat swelling, it projected as much as $1\frac{1}{2}$ lines in some places, its extent being always limited by a sharp border, with steep edges. The color of this new formation varied from normal skin color to a dark, reddish brown. The upper surface of the diseased places was always smooth, rarely shining. The most striking objective symptom consisted in the extraordi-

narily complete induration of the affected places, which had an almost ivory-like feel. Besides this, the patients experienced but little pain, and usually only when the formation presented itself localized on the inner surfaces of the nose, and when these prominences were pressed.

In all cases the development progressed very slowly, requiring several years before the trouble had acquired dimensions, which obliged the patient to seek medical aid.

The impression made upon me by the first case I saw, was that of a syphilitic disease, as the brownish-red, pea-like elevations had localized themselves partly on the upper lip, partly on the inner surface of the alæ nasi and septum, after the manner of a circumscribed tubercular syphilide, and only differed from the ordinary characteristics of that affection by the unusual hardness of the morbid production. It chanced that soon after, during treatment of the first, a second case was admitted to my division in the General Hospital, which, besides the hard tubercle of new formation on the nose, also presented all the pathognomonic symptoms of an acute specific ulcerative angina, so that I was only the more confirmed in my opinion, and looked upon the malady as the result of syphilis. The treatment by inunction was now introduced in both cases, with the daily administration of two pints of Zittmann's decoction, with the local application of emplastrum hydragryi to the hard protuberances on the nose and upper lip, a treatment by which, if, however, sometimes only temporarily, syphilitic products are always induced to undergo retrograde metamorphosis. But in the cases mentioned, this treatment was entirely insufficient; for although the pharyngeal ulcerations of the second patient healed and cicatrized in the usual manner, the extent and induration remained undiminished. A similar ineffectual result was experienced from a continued treatment with iodine, so that my opinion of a syphilitic origin of the malady wavered. It was, however, more shaken by further observation of cases. Thus, the third case was that of the mother of a royal officer of high rank, an elderly lady, who had suffered from this malady for many years, and had been treated at different places and times and in manifold ways by other physicians,—with mercury, iodine, arsenic, and nevertheless presented a slightly enlarged nose, of the hardness of ivory, and of a bluish-red color. The fourth and fifth cases again occurred in men, with the same symptoms, course, and similar obstinacy to all medical treatment. On the upper lip there were several tubercles, partly crowded together, and partly connected, having the size of peas, and the hardness of ivory,

from which a portion was removed to examine their structure microscopically. At the same time in this case, the whole of the left nostril, skin, and cartilage, had the ivory hardness, and was distorted upwards and outwards, not, however, differing in color from the healthy skin.

The most beautiful and instructive cases of this rare disease are, however, those which at the present time are under my observation. Two of them present the tuberculous indurations principally on the nose, especially on the inner surface of the alæ nasi—in one female patient a tubercle is also situated on the outer surface of the right half of the nose; the third female patient, however, not only presents a completely indurated nose of a dark-red color, but also three ivory-like pale-red protuberances surrounding it. Two of these are situated one on either side of the nose, extending from the inner canthus to the upper lip—which remains intact—and not only completely fill the depression between the side of the nose and the cheeks, but also overlap with their particularly hard sharply-margined edges the surface covering the zygomatic arch, from whence they slant towards the nose. The third protuberance is situated on the os frontis, has a length of one and a half inches, and width of a half inch, and extends from one eyelid to the other, it is similar in color to the normal skin, and somewhat less indurated than the two lateral ones, but pressure on the eyelids prevents their opening.

When I saw this last mentioned case, I recollected having seen a similar one in Paris in the year 1852, in an elderly lady. As I did not visit the lady as a physician, but was only introduced to her as a guest, I could make no inquiries concerning her history or the physicians who attended her, in order to consult with them about this, at that time, to me, puzzling disorder. I afterwards ascertained that her attendant was a homœopath, a powerful invasion against the malady had, therefore, not been instituted, and that the trouble remained *in statu quo* up to her death.

After having given a sketch of the cases observed up to the present time, we find the following characteristics common to all :

1. In their constant seat on the nose, and sometimes also in its immediate vicinity.
2. In the extraordinary induration of the affected parts.
3. In the exceedingly slow development of the pathological product, which appears either in the form of dark, brownish-red tubercles or knuckles, or as induration of the normal appearing tissue.

4. In the sharp margination of these indurations, and the absence of all œdema or inflammatory symptoms in the vicinity.

5. In the absence of all apparent metamorphosis of the new formation, as it neither degenerates, ulcerates, softens, nor is absorbed.

6. In the failure of all internal treatment, even with the strongest agents.

7. In the absence of all danger to the system at large, even in case of its existence for many years.

8. Lastly, in the insensibility and painlessness, when the diseased parts are left untouched, severe pain on the contrary, when the dark red tubercles are pressed.

As the localization of the trouble in the face in eight out of the nine cases rendered it impracticable to remove even small particles of the new formation with scissors, we had to defer the microscopical examination until the acquisition of an appropriate case.

When, at length, such an one presented itself, the apex of the isolated tubercle was removed, and carefully examined by my assistant, Dr. Moriz Kohn; he found the epidermis and the layer of the rete Malpighii of normal appearance. Between the elements of the latter especially there were no abnormal occurrences.

The papillæ were somewhat longer than usual, conical or knobby; their external connective-tissue structure markedly wasted; the connective tissue of their body only present as a network of delicate fibres and small intervals; their blood-vessels scarce and thin. The connective tissue of the vascular stratum also present only as a pale, thin, delicate network of fibres. This network of the vascular layer and of the papillæ was filled with small cells, crowded closely together, and the infiltration of cells, at different places extended down deep into the corium, was, however, found regular, and close only in the vascular stratum and in the papillæ, which latter especially appeared stuffed with cells. The cells were smaller, especially in the protoplasm, than the granulation-cells as a rule are, as we meet them in acutely or chronically inflamed tissues, and in places where the formation of new connective-tissue is in progress. The nuclei of the cells were small, little refractive, and finely granulated.

The cells appeared simply stored away in the delicate connective-tissue structure of the papillæ, and the upper layers of the corium, and by agitation were easily displaced.

The deeper layers of the corium showed a close connective-tissue arrangement, which had remained more free from the

described formative elements. The layer of fat-cells normal. Only spare cells in the fibres of the connective-tissue net here present, and there principally in the vicinity of the vessels.

Sebaceous and sudoriferous glands could not be found in the sections examined. The hair-bulbs, external and inner root-sheath of the hair were free from all foreign formative elements, while the papillae bordering on the hair follicle, appeared crowded full of the above-described cells.

The above-described sclerosis of the skin, is, therefore, by this explanation a cell-infiltration of the upper layers of the corium and the whole papillary body. The normal structure of the affected tissues has thus far suffered by the massively accumulated new formative elements, so that the connective tissue structure of the papillae, and of the upper part of the corium is forcibly separated and crowded out, and its elements are renewed.

The cells of the new formation nowhere exhibited that pale, dusted (finely granulated), indistinctly nucleated, not sharply contoured appearance (so-called degeneration) of the cells in syphilis and lupus; but they appeared well preserved, with sharp contour and distinct nucleus, and imbibed carmine well.

We believe, on the strength of the above microscopical characters, which certainly made the clinical facts in the character and course of the new formation intelligible, though only imperfectly explainable, that this rhinoscleroma may be placed histologically next to the glio-sarcoma or granulation-sarcoma (Virchow, Billroth).

In conclusion, I may be allowed to state something regarding treatment, hitherto of but little avail. In two cases, where the tubercles projected from the inner surfaces of the nostrils into the nasal cavity, and effectually prevented the ingress of air, I have destroyed the tubercles with caustic potassa in substance, and after separation of the slough, have produced cicatrization by a frequent coating with concentrated solution of nitrate of silver (aa. p. aeq.). Compressed sponge introduced was effectual in preventing contraction of the cicatrix, and thus the perviousness of the nasal entrance, and the possibility of unimpeded ingress and egress of air was maintained. It is of importance to observe that after destruction of the new formation with caustic potassa no regeneration took place, as this is observed in other formations, as for instance, epithelioma, and also that the neighboring morbid product was neither disposed by the induced action to retrograde metamorphosis, nor to more rapid development.

Epitome of Current Literature.

Dactylitis Syphilitica.—Dr. Locke, of Berne, has observed two cases of a curious affection of the fingers and toes, produced by syphilis, which has no resemblance to onychia, and which is developed coincidently with the lesions of the osseous system :

Case I.—A man aged 45 had complained of very acute pain in the sternum, which was soon followed by swelling of that bone, and also a swelling at the left sterno-clavicular articulation. In April, the little finger of the right hand, and the great and second toes of the left foot, and the second toe of the right foot swelled. The swelling consists in a uniform thickening of the tissues, involving all the phalanges. The creases in the integument at the phalangeal articulations were effaced. The skin was pale, tense and resistant, and the nail was unaltered. They were not painful upon pressure, but movement was impaired.

He was admitted into the hospital in the middle of April, and was then much emaciated. He experienced pain in the knee, and also in the nucha. There was a hard, uneven tumor, of the size of a pigeon's egg, upon the sternum, and another much larger tumor on the left sterno-clavicular articulation. The left knee joint was enlarged from thickening of the articular capsule and an effusion into the cavity. Pressure upon the fourth cervical spinous process gave acute pain, which was also experienced when the head was moved. It was evident that there was disease of the body of the vertebræ. There were traces of previous ulceration in the pharynx, and there was cervical adenopathy. It was impossible, from the extreme prostration of the patient, to obtain a correct history of his disease. The lesions above detailed pointed to a syphilitic origin, and indicated its treatment.

In consequence of taking iodide of potassium, the patient was suddenly seized with dyspnoea and thoracic pain, but there was no recognizable lesion. The heart's pulsations became irregular, and the pulse intermittent, but there was no *bruit*. Digitalis was then given, and the use of iodide of potassium suspended.

As, at the end of ten days, the eardiae symptoms had disappeared, he was treated by mercurial inunctions. After twenty-four frictions had been used, there was improvement in the articular trouble of the knee, and less phalangeal swelling, but the nodes were unaffected. Wet cups were applied to the nucha, with the effect of diminishing the pain. The use of iodide of potassium was again essayed, but it could not be persevered in, on account of the eardiae symptoms. The swelling of the toes subsided, but when the joints were moved, *crepitus* could be distinctly heard. As all the symptoms, except the node on the sternum, had disappeared, the patient left the hospital in July.

Case II.—A man aged 50 entered the hospital on the 15th of May, 1865, for gangrene of the scrotum. He stated that he had had no disease, but called attention to an indolent engorgement of the inguinal ganglia. Early in 1865 he had noticed that the left half of the scrotum swelled at night, and that it gradually invaded the right half. In March the pains were slightly acute, and were made more severe by a fall, and then the skin assumed a bluish color. On the 5th of May he accidentally received a blow upon the scrotum with the handle of a pick-axe, which broke the skin, and from the wound a considerable quantity of a sanious fluid escaped. Upon admission the patient was pale and emaciated. There were two irregularly-shaped gangrenous ulcerations upon the scrotum, which were limited by portions of a detached skin. The ulcers corresponded to the position of the two testes, which were exposed, and between the two was a band of tissue, which had also become detached. The base of the ulcers was sanious, and the edges bluish. The inguinal ganglia, particularly the crural, were much enlarged. Examination of the thoracic and abdominal organs only showed a slight pulmonary catarrh. The only attributable cause of the gangrene was the anæmic condition of the patient.

The blood was examined microscopically, and it was found that there was great excess of the white corpuseles. Local treatment was deemed of most importance, and such mild caustics as camphorated aromatic wine and permanganate of potassa were used. But the ulceration increased, and the two ulcers coalesced and involved the sheath of the penis. The two testicles became completely denuded, and the left was superficially ulcerated, and they were sustained by a large bandage applied below the thighs. The pressure of this bandage caused some sloughing in the inguinal region, which extended considerably, and the inguinal ganglia sloughed out.

The patient was sustained by an abundance of wine and nourishing food ; but still the ulceration showed no signs of cicatrizing until the iodine treatment was adopted, under the influence of which that process was accomplished in about two and a half months.

On the 2d of October the patient again entered the hospital, as the cicatrices had undergone gangrenous ulceration and the testicles had again been laid bare. The cicatrices in the thighs had also ulcerated. On the body of the sternum was observed a tumor of the size of a pigeon's egg, and elastic to the touch, and very painful. The patient was not feverish, although he coughed and had bloody sputum. Auscultation and percussion failed to reveal any lesion.

Under the internal use of iodide of iron, and an appropriate external treatment, the ulceration on the scrotum ceased in about three weeks ; but that on the thigh did not yield as readily.

As fluctuation was observed in the tumor on the sternum, it was incised, and from it gummatous masses escaped, and then it was evident that the bone was carious. A tumor was noticed, about the end of November, at the right sterno-clavicular articulation, and about the same time one of his knees became swollen and painful. The pulmonary catarrh increased, and the patient had several attacks of hæmoptysis. Dulness and mucous-rales were then heard in the right infra-scapular region. At this time a rupial eruption appeared upon the right thigh. He again left the hospital, and again re-entered in January, 1866, complaining of his pulmonary catarrh and hæmoptysis. Localized bronchial breathing was heard over the space where dulness had been observed. The ulcerations were now only very superficial, but the rupial eruption upon the thigh had formed a large kidney-shaped ulcer, with sharply cut edges, and in the centre of which were islands of newly-formed epidermis. The site of the tumor on the sternum had undergone deep ulceration, and two other tumors had formed, and there was also a very painful swelling on the shaft of the ulna, and another on the right clavicle. Mercurial inunctions were ordered, but, after several had been used, the great toe of the right foot swelled indolently, and uniformly involved the two phalanges. An elastic tumor was noticed on the last dorsal spinous process. After the thirty-sixth inunction the gummy tumors subsided, but the swelling of the great toe continued, in spite of continuous compression. The patient was then sent to Schinznach to use the sulphur waters, but again returned to the hospital much debilitated. The ulcers

had again opened, the swelling of the great toe was much increased, and the three phalanges of the second toe of the left foot were also swollen; the integument was somewhat red, tense and resistant. The movement of the articulations of the affected toes was much impaired, and slight erepitis was heard. There was slight ulceration in the interdigital spaces. The treatment was of a supporting character, combined with iodine, under the influence of which the patient was almost completely cured in September; but there was a persistent swelling of the two toes. Again, however, he was obliged to enter the hospital, with an intense pulmonary catarrh and two ulcerating gummata, one on the left parietal bone, the other over the tibia. This time he was treated by baths, the use of iodide of iron and compression to the toes. He left the hospital for the last time in December and was completely cured, and has not had any manifestations of his disease since.

The author thinks that the articular affection is a secondary result to the thickening of the capsule, and that the impediment to the circulation, due to the swelling of the parts, induces alteration in the cartilage, which is less resistant by reason of its limited vascularity.

Dr. Erlaek has likewise observed three cases of daetylitis syphilitica:

I. A woman, aged 48 years, who had secondary syphilis, with psoriasis, headache and indolent enlargement of the phalanges of several of the fingers, was cured in eight months.

II. A young girl, aged 19, had a general rupial eruption in April, and in November a uniform enlargement of several of the phalanges of the fingers.

III. A young girl, aged 17, became syphilitic in 1855, and was treated without mercury, and later several of the joints of the fingers became thickened.

When daetylitis is of long duration, it is very rebellious to treatment. Iodide of potassium and mercurial friction seem to have only a limited influence over the lesion, whereas the topical application of tincture of iodine, combined with compression, produce the best results.—*Archives Générales de Médecine*, April, 1869.

On Tuberculous Ulcers of the Mouth and Tongue.—M. Trelat describes an ulcer, or ulcerating tumor of the tongue, which has hitherto been very vaguely known and indifferently described. In the month of July, 1868, he had under his care, at the St. Louis Hospital, a young and vigorous man, upon whom there were no traces of syphilis, and who also denied

ever having had the disease. He had a firm, rather than hard nodule upon the left side of the tongue, a little anterior to the middle. This nodule was ulcerated upon its summit, which pointed somewhat towards the inferior surface of the organ. The borders of the ulcer were sharp, the base had a reddish-gray, mammelonated and fungating appearance, and it was of the size of a centimètre, and its contour was irregular. There were near the ulcer superficial rosy lesions, and later there appeared, near the frænum, yellowish-gray spots.

The ulcer was regarded neither as due to the irritation of the teeth, nor as an epithelial formation; and although the patient had not had syphilis, in the absence of other indications he was put upon an anti-syphilitic treatment, with no results. The ulcer was then seen by M. Hardy, who was inclined to regard it as the initial lesion of syphilis. A suitable treatment was adopted, with likewise negative results. As the ulcer continued to be a source of annoyance, and by it mastication was impeded, borax, tannin and tincture of iodine were tried, hoping to relieve the distress. In February, 1869, his general health became bad, and extensive pulmonary lesions were discovered. At this time, by the advice of M. Broca, without arriving at a satisfactory diagnosis, the actual cautery was applied to the ulcer. The result was good, as by it the impediment to mastication was removed and the uneasiness lessened. Soon after, an acute pulmonary tuberculosis supervened, to which the patient succumbed. In the lungs and on the mesentery, large quantities of tubercles were found. Tubercles were also discovered in the mucous membrane of the tongue.

Here was a case in which, seven months previous to the cachexia of the tuberculosis, a localized deposit had occurred in the tongue; and, at the time of its first recognition, neither objective nor subjective symptoms pointed to lesion elsewhere.

A somewhat similar case was recorded by M. Buzenet (*du chancre de la bouche, son diagnostic différentiel. These Inaug.*; Paris, 1858), in which the ulcer preceded general constitutional symptoms. The fact of ulcers occurring in the mouth and about the larynx in the advanced stages of tuberculosis is known to every practitioner; but their occurrence has not been noticed elsewhere so long in advance of positive symptoms, so that M. Trelat thinks that the hypothesis is at least feasible of there being two varieties of ulcer—the one really tuberculous, the other an impairment of nutrition in consequence of the cachexia. The observation of Cruveilhier and others certainly prove the existence of tubercles in the substance of the various mucous membranes. In the mouth these ulcers are va-

riously found on the tonsils, the palate, the tongue, cheeks, the gums and the lips. Their appearance is modified by the structure upon which they are developed ; on the tonsils, where they penetrate the follicles they are jagged and irregular, and upon the cheeks and palate they are flat. Their course is chronic, with a tendency to invade new surfaces, so that they have been known to involve the whole tongue and to almost occlude the isthmus of the fauces. They never retrograde spontaneously, and their cure is very doubtful. At first they are indolent, but as they extend they become painful and impair the functions of the mouth. There is sometimes an abundant and troublesome flow of saliva, but the parotid and the submaxillary ganglia rarely if ever are involved. The ulcerations are superficial and irregular, penetrating cavities are not found in them, nor those hard salient vegetations so common in canceroid and carcinoma. Their base is a greyish or yellowish red, often covered with a mucous glazing which is very adherent at the edges which are sharply cut, red and irregular. The ulcer reposes upon a base more or less voluminous or hard, sometimes perhaps elevated, appearing as a tumor. The fact of the appearance near the ulcer of red points, which are ulcers in a condition of inception, is considered as pathognomonic. These ulcers are developed in the following manner : there is noticed one or more small slightly elevated spots covered with epithelium, on which the orifice of follicle is noticed. The color of the spot is yellow at first, but later, owing to the abrasion of the epithelium, it is reddish-yellow and ulcerated. The observations of M. Trelat as to the origin of the ulcer are confirmed by Jalliard and Duplay, and M. Gabler says that they appear ordinarily by an engorgement and inflammation of the glands, followed by ulceration. It is assumed, then, by M. Trelat, that a chronic ulcer, superficial and rebellious, having edges irregular without inflammation of the neighboring glands, occurring upon the tongue or in the mouth, is in many cases a tuberculous ulcer, and the diagnosis is certain if the peculiar spots are found, as they do not exist in any of the other varieties of ulcer of the mouth. As regards the diagnosis of the ulcer when fully developed, there is an apparent resemblance between it and syphilitic ulcers ; but neither the true chancre nor the mucus patch nor the gummy tumor develop themselves as does this form of ulcer, and the effects of treatment are invariable guides as to syphilitic origin. As regards the treatment of this form of ulcer, the use of the usual stimulant and astringent lotions is futile ; and, although the prognosis as to life in some cases is grave, yet the distressing symptoms

which these ulcers entail, fully warrant the application of the actual cautery. The paper concludes with the following aphorisms :

1. It is demonstrated that the ulcers of the mouth known by the names of *buccal phthisis* and *tuberculous ulcers* are, in certain cases at least, produced by the ulceration of true tubercles ; the fact has not hitherto been admitted.

2. Tuberculous ulcers of the mouth have always been observed in tuberculous individuals, but their apparition may precede that of the pulmonary tuberculosis, although the inverse of the proposition is of most frequent occurrence.

3. The diagnosis of the ulcers may be surely established at all periods of the disease.—*Archives Générales de Médecine*, January, 1870.

On the Influence of Syphilis in the Production of Tubercle.—Dr. Hermann Lebert, in two short lectures, calls attention to this important and as yet almost untrodden field of pathological research ; the views which he propounds have additional weight, as emanating from so accurate an observer. The subject of his remarks was a young girl eight years of age ; who up to a short time previous had not given any evidence of tuberculosis ; she had coughed occasionally, but not long or severely. Her mother, though she coughed and expectorated, gave no signs of tuberculosis ; her father, however, died of phthisis, and two of their children died in their first year.

The patient became inoculated in an obscure manner, probably in a rape, and presented unmistakable evidences both of syphilis and tuberculosis. The chain of glands anterior to the sterno-cleido-mastoid muscles were enlarged, hard and agglutinated to one another by proliferated connective tissue, and to touch and sight were suggestive of the tubercular lymphadenitis of scrofulosis. The chain posterior to the muscles presented characters peculiar to the adenopathy of syphilis, the same condition obtained in the inguinal glands. Distinct syphilitic lesions were present in the mouth and upon the tongue and tonsils, in the form of rhagades, ulcers and mucous patches. The genitals were also markedly affected ; the hymen was ruptured, the labia much congested and an indurated chancre, in a transition-stage to a condyloma, was situated upon the posterior commissure of the vulva, and other condylomata were present in the neighborhood and particularly upon the arms. A macular syphilide, which in some places desquamated, was scattered over the body. The health of the patient seemed as if becoming impaired, appetite was fair, bowels were

regular, but she coughed, and at lower part of right apex prolonged expiration and rhonchi were heard. It is assumed that the child inherited a taint from her father, and that the rapid gland-infiltration and disseminated deposits in lungs were caused by the action of the syphilitic virus. This fact of the awakening of a dormant predisposition to tuberculosis by syphilis Dr. Lebert has frequently observed, as well as the power of syphilis to produce tuberculosis where no predisposition had existed. The microscopical appearances of the neoplasm, produced by syphilis in the lung, are not at all distinctive; they do not resemble gummy tumors, and in fact cannot be differentiated from the same lesion produced by the cachexia of tuberculosis; they may be regarded as a perversion of nutrition by profound infection of the organism, the morbid processes in either instance producing very similar results. (Well-defined gummy tumor, however, is sometimes found in the lungs.) Having established the fact of the development of tuberculosis of the lungs and glands by syphilis, attention is called to the necessity, in cases of phthisis, of the recognition of the syphilitic cause, if it exist, and the institution of the treatment indicated. Dr. Lebert has himself seen marked amelioration and even permanent recovery in such cases under the influence of proper medication.

The treatment of this particular case was by the inunction of 16 grains of mercurial ointment; at first once daily, subsequently twice each day. The mode of inunction directed is somewhat peculiar: "A piece of bladder is to be moistened and then allowed to dry only so far that it may still remain soft; this bladder, when filled with cotton-wool, constitutes a tampon on which the ointment is to be placed and by means of which it is to be rubbed in during about fifteen or twenty minutes at a time. The inunctions must be made at different places alternately, so as not to cause an eruption at any of the places." In the use of mercury for constitutional syphilis, Lebert very much prefers the inunction to other modes of administration, as it acts more efficiently, is less liable to disturb digestion, or to produce those unpleasant symptoms of ptyalism which though not syphilitic very much annoy the patient. He adverts to the fact that inunction at one period fell into disrepute, by reason of the fact that physicians when using the treatment confined the patients to very warm atmospheres and low diet. He regards salivation as injurious and thinks that as anaemia and impaired nutrition are unfailing concomitants of syphilis, low diet and the debilitating influences of high temperatures are very prejudicial and to be

avoided. He summarizes his views as to the administration of mercury and the treatment of constitutional syphilis as follows: 1. Mercury is preferably administered in the form of inunction to that of hypodermic injection or by the mouth. The quantity daily required by the method is thirty-two grains. 2. Combined with mercurial inunction, an invigorating and nourishing diet is necessary, avoiding any digestive disturbance. The patient should not be confined to his room, but may be active in out-door pursuits, if he avoids cold and wet. 3. Ptyalism is always to be avoided; this is accomplished by washing the mouth with common water, by frequent bathing and by the use of chlorate of potash both internally and as a gargle when the first signs are noticeable. 4. Avoiding unnecessary fasting and perspiration, the course can be pursued without attracting notice, can be continued indefinitely, and repeated in case of relapse. 5. In inveterate cases of constitutional syphilis, good effects follow the combined internal administration of iodide of potassium with the inunction.—*Med. Times and Gazette*, Nov. 27th, 1869.

Nervous Symptoms depending upon Intra-Cranial Syphilitic Disease.—Dr. Hughlings Jackson has under his care, at the National Hospital for the Epileptic and Paralyzed, several cases presenting symptoms of syphilitic disease of the brain. They are double amaurosis from optic neuritis or its sequela, atrophy, with convulsions which begin unilaterally, most frequently in the hand. The inferences are that the convulsions are due to change in the side of the brain opposite to the side of the body in which the spasm occurs, and that the optic neuritis leads one to suppose that the pathological change is a "gross" one, a lump of something which Dr. Jackson affirms from experience is most generally of syphilitic origin. The association of such symptoms are then the empirical and not rational evidence of syphilitic lesion. In the *Lancet* of Oct. 28, 1868, and in the fourth volume of the *London Hospital Reports* are recorded three such cases, which are worthy of being reproduced.

Case I.—A man aged 24 was admitted in January, 1868, for convulsive seizures, each of which began in the left hand. After each severe fit he was weak of the left side. His sight was apparently good, but his field of vision was not tested. Nevertheless he had double optic neuritis (descending). His eyes were examined by several accomplished ophthalmoscopists. The patient had also severe pain in the head. Now the disorder of the unilateral muscular region and the "epileptic hemi-

plegia" showed plainly, Dr. Jackson believed, that there were pathological changes in the corresponding cerebral hemisphere. The pain in the head and the optic neuritis showed that the internal local disease was "course," and the subsequent cropping up of a node on the right side of the head declared that the "course" disease was syphilitic. The fits continued at irregular intervals, and besides the muscles of the affected arm were the seat of a great variety of abnormal movements. It is important to observe that, after one severe fit, the right third nerve was palsied. The patient's sight failed a few weeks before his death (Aug. 29th), and on the 8th of August they presented the appearance of the "swollen" disc. As was easily inferrible during the patient's life, there was found at the autopsy a syphilitic map, or rather, a cluster of syphilitic nodules, growing from the dura mater, and seemingly pressing the pia mater before it into the right cerebral hemisphere. Iodide of potassium was given in large doses, ten and twenty grains, but did little good. The bromide was also given.

Case II.—W. W., aged 38, came under Dr. Jackson's care Jan. 4, 1867. He was partially hemiplegic of the left side, subject to convulsive seizures, and had defect of sight. His trouble began by a convulsion Jan. 30, 1866, he having previously suffered from syphilis, of which there was positive evidence. He described the sensations he experienced previous to the convulsion as of a crawling character, beginning in the finger of his right hand, running up the arm to the face and eyelid; there was besides alternate contraction and relaxation of the fingers and a twitching in the eyes. He remained in the paroxysm ten minutes, and when it had passed off he was very violent. Since that time he has been hemiplegic. His sense of smell and taste were impaired, his sight failed three months after, and a persistent headache troubled him. In June he became amblyotic and squinted. He was deaf, but had been so previous to his illness. Sensation was not perceptibly altered on the cheek, though there was a slight deviation from the left. Tongue was straight, voice was not affected, but speech was slightly thick. Sensation was equal on each side. He had pain on the right temporo-parietal region of the space of two square inches, and slight pain at the back of the head.

The ophthalmoscope showed the disc to be of a dirty white color, ill-defined though prominent; the veins were tortuous and the upper large ones were partially obscured in the disc substance. The arteries likewise appeared thin and obscure. The fundus was normal beyond the disc. He received good diet and ten grains of iodide and fifteen of bromide of potas-

sium three times a day. He had during January several slight seizures, but in February he was much improved. Motion in hand was freer, he could walk better and his sight was much improved. He passed from observation in April, and was not seen again till November; in the interval he had had but two fits. He then had a rash on his face which left cicatrices and also a node on the vertex. The optic discs were whiter, the vessels were small and near disc was some pigment. With the right eye he could read No. 6 Jäger with some difficulty, but his sight is not sufficiently improved to allow him to resume his position as clerk.

Case III.—Elizabeth C., aged 28, married, came under observation March 26, 1867. Her first fit was on Christmas, 1865, but had been ill nine months previously. At 7 A. M. on that day she lost her speech, and while asleep, two hours later, passed unconsciously into a fit; the left arm and legs being the parts affected, as stated by her husband. These members have since that time been more or less affected. She since has had fits, one a month or sometimes every few days. The power of speech was afterwards regained. In the subsequent fits it was noticed that they began in the lips, the tips of the tongue, then the left side of the face worked, the left arm trembled and contracted, and then she passed into insensibility. She had pain in the head and dimness of vision, which had gradually come on during the last five months. The disc resembled very much that of the previous case. She was partially hemiplegic of the left side, and face deviated to the right, but she could close her eyes equally, and tongue was protruded normally. Sense of smell and hearing were normal. She had also for five weeks noticed a queer feeling in the right hand and a shaking of the left leg. The frontal bone seemed swollen towards the left side, but the swelling was larger and shaded off more gradually than a node does. There were, however, nodes upon the tibia, and a syphilitic eruption on the arms and legs. There was no paralysis of any cranial nerve, but she had pain in the head. In June she was much improved, her sight was better and the swelling of the disc was gradually clearing up. She has since June had four fits, each beginning in the same way, and she has peculiar "sensations" in face, arm and leg, lasting for hours.

Case IV.—Was a woman 40 years of age who suffered from symptoms similar to those of the preceding cases. She had fits beginning in the left hand, several times epileptic hemiplegia and optic neuritis. There was a node on the forehead, one on the ulna, and one on each tibia. When first seen she

had no optic neuritis, though its invasion was expected from the presence of severe headache and vomiting. Later it did develop in a marked manner. The left retinal veins were very tortuous, large and dark; the arteries were scarcely perceptible and partly buried in the disc, the margin of which was ill-defined white and "wooly" looking, the whiteness extending beyond the normal bounds, so that the *ci-devant* disc was twice its normal diameter. The condition of the right disc was similar, except that the tortuosity of the veins and indistinctness was greater, and that on the inner and lower border a little blood was effused. She could nevertheless read brilliant. In December she had had three fits and after the third was hemiplegic. There was no doubt in the mind of Dr. Jackson that in each of these three cases there was syphilitic deposit in the right hemisphere. He does not, however, believe that amaurosis from optic neuritis or unilateral convulsions (from corpus striatum neuritis) are in any way characteristic of syphilis.

Case V.—Shows the association of similar kinds of epileptiform seizure with syphilitic symptoms: J. C., aged 33, had had six fits in seven weeks when first seen. When the fit came on, the left hand felt as if beaten with nettles. The feeling passed up the arm to the shoulder, then to the face on the same side, and the whole side of the face, including, as far as could be judged from description, the orbicularis palpebrarum. He had pain in the forehead, not worse on pressure, and it was not worse at night. He had pain over the mastoid process. The left pupil was very irregular and dilated very irregularly by atropine. The eye had inflamed eight months previous, following a chancre. He took pills and was pyralized.

In practice it is very important to know the association of nervous symptoms which syphilis produces, since there may not be any demonstrative evidence, such as nodes. There are, of course, other associations of symptoms having similar complications; for instance, palsies of several cranial nerves, hemiplegia with palsy of a cranial nerve, and palsy of one leg.—*Lancet*, Dec. 11th, 1869.

On the Alterations Produced by Syphilis in the Lung of the New-Born.—M. Depaul presented to the Imperial Society of Surgery of France a case of syphilitic alteration of the lung of the newly born child. The mother, a primipara, 28 years of age, stated that she was in her eighth month of pregnancy, and that she had no disease during that period. She was delivered on the day of her admission of a female child, which weighed 2,470 grammes, or rather less than five pounds.

It was very feeble, its respiration was very irregular and jerking and its chest livid. It succumbed on the next day, having lived about 10 hours. The condition of the child led to a careful examination of the mother, and M. Depaul found undoubted lesions of syphilis upon her. Mucous patches upon labia majora, copper-colored papules upon the palms, redness on right side of the throat and a pleiade of engorged ganglia in the groin, and finally the hair fell. Her statements as to the date of contagion were very unsatisfactory, but it certainly very much ante-dated the child's birth. At the autopsy of the child, it was found that the greater number of pulmonary vesicles had not been dilated by air, and scattered through the lung tissue were large numbers of clear yellow indurated masses of the size of a small nut. The liver upon section was seen to be studded by little nodules of indurated hepatic tissue. No lesions were found upon the skin in the thymus, or in the peritoneal or pericardial cavities. The microscopic examination was made by M. Cornil. Portions of lung were hardened in alcohol and thin sections made. It was then found that the interalveolar walls were very much thickened and the alveoli very much narrowed. The walls were formed of an embryonic connective tissue, with vessels and a great number of embryonic cells. The walls in some places were so much thickened that the alveola cavities were completely obliterated, whereas other alveoli were filled with epithelial cells, pus corpuscles, and granular debris which had undergone fatty degeneration. In reporting the case, M. Depaul remarks that he is fully aware of the differences in opinion as to whether the syphilitic child ever presents at birth traces of the disease, or whether they appear later. He quotes the opinion of Ricord, who basing his opinion upon the mode of evolution of acquired syphilis, maintains that a child tainted with hereditary syphilis does not at birth show any signs of syphilis. M. Depaul, however, maintains, and has demonstrated the fact, in about a hundred cases, that syphilis manifests itself at birth by various lesions. These lesions in the lung are regarded by many as tubercles or the product of an intra-uterine pneumonia, but M. Depaul has never observed them other than arising from syphilitic contagion. The same lesions are found in the thymus, and M. Gabler has observed them in the liver. The alterations which occur in the alveoli prevent the penetration of air, and in this way kill the child.—*Gazette des Hôpitaux*, Nov. 18th, 1869.

Contagious Impetigo.—Under this name Dr. Tilbury Fox describes a disease which might be mistaken either for a pustular eczema, or a parasitic disease. It is epidemic in character, is attended with pyrexia, and commences as vesicles or minute bullæ, which enlarge, become flattened, and are replaced by flat yellow crusts. Vesico-pustules may all develop upon the mucous membranes, especially those of the eye. It runs a definite course and is contagious by the inoculation of its secretion upon healthy persons. The disease is found mostly in children of the lower orders, as the out-patients of dispensaries and hospitals, but has been seen in children of higher walks in life. Cleanliness and care prevent the inoculation of the disease, and the want of these essentials and the huddled condition of the poorer classes explain the long continuance of the disease among them. It is a peculiar fact, that the children in whom the disease is developed have previously been perfectly healthy. The disease is ushered in by a well pronounced fever, and in infants convulsions have been noticed as a complication of its invasion. The child appears ill, pale and languid, and has "burning heats" or "cold chills" at night. In a day or two after the invasion the eruption appears. Its usual site is on the face, the top and back of the head, or near a recent vaccination; the hands sometimes are first affected, and look as if burnt. In rare instances it begins upon cuts or scratches, or even upon bites. Wherever it may appear its tendency is to invade other parts, and the distribution is made more general by scratching, by which the patient inoculates other parts. The vesicles and bullæ usually are isolated, but upon the face may become confluent. In five or six days the bullæ, if they are not ruptured, attain the size of a nickel cent, have a depressed and umbilicated centre and their contents are opaque. The secretion by the microscope reveals pus corpuscles and a homogenous fluid. The scabs, which form two or three days after the vesicles appear, are characteristic, having the size of the area of the bullæ, are flat, straw-colored, dry, granular, and appear as if "stuck on." In some cases there is no inflammatory areola, in other more severe cases there is. The disease is superficial, for when the scabs are removed slight ulceration with a viscous secretion is noticed, and "at the bottom a *bouton* of lymph." Pediculi are not to be found; the scabs are not dark nor is their odor offensive. It is quite active in its course, and the fact of the contagiousness of its secretion upon the bearer is not explicable by the hypothesis, that the tissues of a cachectic subject are liable to take on morbid action. On the head the hair of course becomes involved

in the scabs. Itching only occurs at the onset, and then is slight. The salient features of the disease are its apparently epidemic character, its antecedent pyrexia, the presence of the peculiar scabs which appear as if stuck on, and result from the collapse of a bullæ which had developed from a vesicle, the uniformity of the eruption, its contagiousness and absence of itching.

The diagnosis is to be made between four or five affections, eczema, pemphigus, ecthyma, pustular scabies, and impetigo sparsa. From eczema it is distinguished by the discrete character of the eruption, the peculiar crusts and facility of cure. The comparative variety of pemphigus, its persistent blebs, its non-contagiousness, and absence of scabs are sufficiently distinctive to exclude it. Ecthyma begins as a pustular eruption, with much induration and redness, occurs monthly in adults, is painful, non-contagious, and has large, hard, dark, and very adherent scabs. Pustular scabies presents some diagnostic difficulties; it may attack many members of a household, and thus resemble in one peculiarity contagious impetigo. But one feature of the impetigo is the *uniform* character of its eruption, while that of scabies is *multiform*, presenting papules, vesicles, pustules, and acarian furrows. Scabies is itchy, particularly at night; impetigo contagiosa is not itchy; if the scabies is pustular its crusts are dark, differing very materially from those of the impetigo. Even when these diseases attack the feet, these characteristics are sufficiently well marked for a correct diagnosis. The crusts of scabies, properly treated, will show evidences of acari by the microscope. Inoculation may assist also in diagnosis. Dr. Fox is not positively certain what impetigo sparsa is; he thinks, however, that many cases of impetigo contagiosa have been thus denominated; but if it is a small patch of eczema impetiginodes, the diagnosis has already been sufficiently detailed. He recognizes the analogy between the disease under consideration and varicella. As regards the inoculability of the impetigo, he states he has frequently verified the fact, and he details the successful treatment of a skeptical friend, who produced a second series of inoculations. Inoculations are more marked, and run a more definite course, when made upon children than upon adults. As regards the frequency of the eruption, Dr. Fox noticed thirteen cases in the first five hundred under his care, at the Charing Cross Hospital. The treatment is eminently satisfactory, as applications of weak ammonio-chloride of mercury ointment to the ulcerations alters the secretion and renders it no longer inoculable, and a cure is soon effected.

Salines may be indicated in the febrile stage, or tonics in weakly persons, but topical applications are all that are really essential.—*Jour. Cut. Med.*, Oct., 1869.

Feigned and Hysterical Diseases of the Skin.—Under this title Mr. Startin reports some interesting cases. The diseases of the skin which he has most frequently seen feigned are erythema, eczema, pemphigus, ulcerations, morbid growths and discolorations. The first case was that of a married woman about 40 years of age, childless, who, by means of irritating applications, caused an *eczema palpebrarum* which apparently blinded her, but she performed numerous hysterical acts, such as cutting out figures, likenesses, etc., on black paper, which she pretended she could not see. The next case was one of erythema marginatum, by a young girl aged 21. The patches were found on various portions of the body, and were produced by mustard paste applied in the form of various figures, as maps, etc., by means of the camel's hair pencil. The third case in its time excited much interest. It was in the person of a young lady who was supposed to have melanosis of the skin, or congenital syphilis pityriasis nigricans. The skin of the face, temples and in front of the body was covered with patches of dark brown secretion, which was not acted upon by water or spirit, and friction applied to them were said to produce pain. Mr. Startin obtained the lady's consent to brush the parts with a camel's hair pencil, which, having been dipped in ether, readily washed off the stain, which was a mixture of candle black and grease. Visible spots of ecchymosis also were found upon the thighs, produced by pinching. The fourth case was still more striking. It was a young, anæmic, and hysterical lady, the front of whose neck was covered by a thick black incrustation which had been there six months, and was said to be due to coagulated blood which had oozed from numerous points; this oozing could be seen very plainly. A glycerine lotion was ordered with a view of softening and removing the stain, but the continuance was not permitted, as the patient said it disagreed with her. The whole incrustation was then painted over with the flexile collodion by which the air was excluded and evaporation prevented. The day after the application another stratum of the material had been added to the painted surface, but the original was so much softened that it was readily removed. The mass consisted not of coagulated blood, but of the extract of liquorice, minute hairs, and cutaneous scales. The sixth was a case of obstinate ulcer upon the arm of a servant girl, which only healed when the arm was strapped to the side.

Another case was one of a young female who spoiled a large amount of linen by a profuse dark or black perspiration, which was found to consist of soot and milk. The seventh case was that of a girl, who for a chest affection was a patient of the Consumption Hospital. She produced a series of bullæ upon her fingers by means of the blister, which she should have applied to the chest, but the deceit was exposed by puncturing the bullæ and finding that the fluid was very *acid*. It is supposed that she at first accidentally blistered her finger and produced other blisters to excite pity. The eighth case was one of a peculiar form of alopecia, in which the hair in the front of the head would only grow to a certain length and then fall out, in spite of all applications. The microscope revealed the fact that the hairs were cut so very smoothly as only can be done with a pen knife. The ninth case was that of a girl who presented an anomalous ulceration on the fore-arm. The ulcers were in a clustered circular form as large as a nickel cent; some of them had healed and had raised cicatrices resembling keloid. It was suspected that they were the result of caustic application, which was confirmed by the patient's confession. The tenth and last case was that of simulated lupoid ulceration of the neck, which was the result of continual picking. The patient states that "a small lump appears beneath the skin, which she must have out, as the itching is quite intolerable." The result is a most intractable ulcer and unsightly scars. The patient's general health was not good. Mr. Startin adds that during his long illness the patient was not troubled with these ulcers, but that they reappeared at the time of his convalescence and return to practice.—*British Med. Journal*, Jan. 8th, 1870.

Syphilitic Pemphigus.—The Paris correspondent of the *Lancet* saw at the St. Louis Hospital an interesting case of this disease. The patient is a man 38 years of age. In September last he had an indurated chancre and bubo, followed in November by a pustulo-crustaceous eruption, which left stains upon the thighs. At the end of the same month bullæ, attended with swelling, appeared on the palms of the hands and palmar surface of the fingers, which rendered movement difficult. In December a more voluminous crop of bullæ appeared on the soles of the feet, some of which attained the size of a nut. M. Hardy said, in relation to the case, that it was a very rare one, the first in fact which he had seen during the long course of his experience, of about 20 years. The treatment employed was tonics, such as bark and wine.—*Lancet*, Jan. 8th, 1870.

Cases of Syphilitic Affection of the Third Nerve Producing Mydriasis, with and without Ptosis.—M. Victor De Meric reports several cases of this peculiar complication :

Case I.—A gentleman, 30 years of age, having five years previously had syphilis, for which he had been treated, presented, himself with a sparse papular syphilide and a “confused state of vision.” There was a marked dilatation of the left pupil ; amblyopia but not diplopia. Vision was perfect in the left eye. There was no ptosis, nor paralysis of the recti or oblique muscles. He had no pain in head nor derangement of general health. Calabar bean was applied to the eye with the result of temporary contraction of the pupil ; but when the effect of the drug had passed off, the amblyotic symptoms were as bad as ever. Ophthalmoscopic examination of the fundus revealed a healthy retina, but a congestion of the choroid. Iodide of potassium was given in increasing doses, and the calabar bean disk applied for three months, when the symptoms very much improved, a blister was applied behind the ear also. At the end of six month’s treatment his sight was nearly restored, the pupils were equal on both sides, and a year after he states he had had no return of the symptoms, but that after reading sometime at night the letters became indistinct.

Case II.—A lady had several rings of psoriasis of a coppery hue, mucous patches upon thighs and vulva. She was treated for four months, during which time she had a miscarriage. The mucous patches developed into such large vegetations that it was necessary to remove them with a knife. One year after she had epileptic symptoms, which were probably of syphilitic origin. The most interest, however, centres in the case of a gentleman who had cohabited with this patient. He had a very slight palmar psoriasis, enlarged inguinal and occipital glands, also one epitrochlear gland, redness of the prepuce, which scaled. He was treated with mercury with good results. Seventeen months after he complained of the sight of left eye. Some epiphora and slight dilatation of left pupil were noticed. Vision was said to be perfect on the right side, but indistinct on the left. There was much confusion when both eyes were used, but no actual diplopia or ptosis. But ptosis afterwards occurred, and then it was thought expedient to use a mercurial course and a blister behind the ear. Calabar disks were used, as it was found that there was no disease of the deep structures of the eye. The levator palpebræ was feeble, but the other muscles were healthy. The confusion of vision was due to want of accommodation. The calabar bean produced some myopia. Iodide of potassium and iodide of mercury were given

at various times internally, and the electric current to the face and brow, as well as a blister behind the ear. By degrees the circular fibres of the iris regained their power, so that the calabar disks could be left off. In about five months, by means of this treatment, the pupils became normal and the patient could read for two hours without being fatigued.

Case III.—A German, 34 years of age, who, besides other distressing symptoms of syphilis, had had paralyses of almost every branch of the third nerve of the right side. There were evidences of extensive ravages of syphilis, a depression on forehead from loss of bone, falling in of nose, perforation of hand, palate, and almost complete loss of velum.

The urgent symptoms, however, were a considerable swelling of the soft parts around right eye, and a fluctuating tumor towards inner canthus. The abscess burst and extensive caries was found of the lachrymal bone, and the nasal process of superior maxillary bone. When the reparative process was complete there was an immobile condition of the globe and also a dilatation and insensibility of the pupil. The levator palpebræ was not injured. The treatment was iodide of potassium in large doses, bark, and a generous diet, and solution of the extract of calabar bean to the eye, which always produced temporary contraction of the pupil. The paralysis of the recti and oblique muscles was not influenced by treatment, and vision was very imperfect. No very marked pathological change was noticed in the deep portions of the eye. After four months treatment the patient left the hospital much improved generally, but his eyes were not much benefited, as the pupil still continued widely dilated. He could see figures at 15 and 20 feet distance, and when pupil was contracted by calabar bean he could read Jäger No. 20 type.—*British Med. Journal*, Jan. 8th, 1870.

Varices of the Superficial Lymphatic Plexus of the Penis and Scrotum, following a Contusion. — M. Trelat presented to the Imperial Society of Surgery of France a cast of a case of this rare form of varix. The history of this case is very interesting. A mason entered La Pitié October, 2d, 1869, with a swelling of the penis, which had existed eight days. He had been pushed violently against the corner of a wooden table, and struck the penis on the dorsal surface of its base. Acute pain and swelling followed, with fever, and he was confined to bed until his admission into the hospital. At that time the penis was very much swollen and œdematous, the glans was completely hidden, and there was no urethral

discharge. The œdema was hard, and of a bright red, especially on the free extremity of the prepuce. Pressure was not painful except at the point of injury, which was swollen. The œdema had extended to the scrotum, and at first showed a tendency to extend. On the dorsum of the penis, near the median line, a red, semi-transparent papular elevation, hard to the touch, appeared on the day of his admission, followed by another on the next day. When these papules, which were firmer and more durable than those of herpes, were pierced with a pin, a transparent, yellowish, slightly coagulable fluid exuded, which was more abundant when the prepuce was pressed upon. Microscopic examination of the fluid showed it to be lymph, and to consist of white globules in abundance, and oily molecules. For eight days these elevations continued to appear, and then completely covered the dorsum of the penis and the anterior aspect of the scrotum. Continued microscopic examinations still revealed nothing but the leucocytes and the molecular fat. In consequence of the long-continued close coaptation of the glans and the prepuce, a slight balanitis was produced, but he did not have, at any period of his illness, the slightest urethral discharge. The inguinal ganglia were not at all involved, as the disease was strictly confined to the limits described; nor were lymphatic cords noticed. He was treated by starch baths and continuous manual compression, as all other expedients had failed. The œdema diminished first from the scrotum, and the elevations sank down, leaving no trace on the skin; and when he went out of the hospital, October 26th, the penis was only slightly œdematous. He had enjoyed good health, had never had such a lesion previously, but from a blow on the scrotum had had an ecchymosis.—*Gazette des Hôpitaux*, Nov. 23d, 1869.

Herpes Epizooticus Contagiosus.—Mr. Curgenven reports the following cases, which he regards as cases of herpes, “in which the whole system is involved,” and for which he proposes the above name:

A coachman, aged 22, married, of sober habits, inhabiting a newly built stable in a healthy locality, and previously of good health, was attacked October 13th, with sore throat, shivering, and vomiting of watery mucous, which he described to be “as green as grass.” The next day there was muscular soreness of the trunk and limbs. The skin was hot, face flushed, pulse over 90, tongued and clean. There was a white patch of herpes on each tonsil, redness and swelling of fauces, swelling and tenderness of submaxillary glands, difficult and painful

deglutition. On the 16th, there was more swelling of the mucous membrane of the pharynx, and greater difficulty in deglutition. The pimples on the tonsils had coalesced into uniform white patches, but had not extended, others had appeared on the uvula and both surfaces of the tongue, which organ continued red. On the 17th, he was found to have slept little at night, being disturbed by difficulty of breathing, and by the accumulation of large quantities of thick, tenacious mucus in the throat, becoming delirious towards morning. He discharged, by retching, about six ounces of thick, jelly-like mucus, which adhered firmly to the bottom of the basin. The inflammation, possibly the herpetic eruption, had extended down the œsophagus, and into the larynx. He was quite hoarse, talking scarcely above a whisper. Clusters of herpetic vesicles had appeared at the corners of the mouth, at the nostrils, on the eyelids, near the inner canthi, on the left side of the scrotum, and prepuce, with single vesicles scattered over the thighs, forehead, and the backs of the hands. There was partial loss of power in the hands and wrists; he could not close the hands, nor straighten the wrists. Temperature high [degree not stated, nor whether it was ascertained by the thermometer or otherwise]; pulse 98, bowels regular. On the 19th he had had a better night, but continued to bring up a quantity of thick mucus after each dose of the medicine (chlorate of potassa and hydrochloric acid). There was a patch of vesicles on each side of the neck, immediately over the tonsils. These, about a dozen in each patch, had not coalesced, but the vesicles of all the other patches had, forming one scab for each group. That on the scrotum rubbed off, leaving a raw surface. His hands and wrists had recovered their power, which might or might not have been due to a blister applied between the shoulders the previous night. His wife complained of lassitude, slight shivering and sore throat. She had a patch of herpes on the left tonsil. Tongue slightly coated, pulse 84, skin hot.

On the 20th, the husband's symptoms were improving. He could swallow better, and took a little bread in his beef-tea. The discharge of mucus was less. The wife had a patch coming on the right tonsil. His mother, who had sat up two nights with him, and had been with him more or less from the commencement, had a patch on her right tonsil.

On the 21st, the husband was better. Temp. (by thermometer) 100°. His wife vomited yesterday and to-day a watery fluid. She had muscular soreness, heat of skin, pulse 92, aching of the hands. His mother had muscular soreness and

aching pains in the hands. A patch had appeared on left tonsil. Tongue slightly coated, pulse 90.

On the 22d, the wife had several red spots on her hands last night (*“Herpes sine vesiculis,”* Wilson), only two or three of which, on the left hand, gave rise to vesicles. The disintegrated mucous membrane over the spots of herpes, on the husband's tonsils and tongue, had been cast off, leaving ulcers with well-defined and healing margins.

On the 26th, the husband was still hoarse, the wife and mother were almost well, their throats being only slightly sore. The herpes was gone. Husband's voice gradually returned during the next few days. Cuticle is peeling from the hands and feet.

On the 27th, the husband's brother was attacked with shivering, sore throat and fever. He had a group of white pimples on each tonsil. Tongue coated, pulse 102, skin hot and perspiring.

On the 28th, pimples less perceptible, pulse 120, occasional cramp in feet.

On the 29th, eruption on tonsils was gone, tongue coated and swollen. Had a troublesome cough last night. No chest symptoms. An inflamed gland in right axilla.

November 1st, copious perspiration, occasional cough and cramp in feet. Pulse 84.

SECOND GROUP OF CASES.—October 22d, a housemaid in a family had had shivering and muscular soreness, without sickness. She presented a patch of herpes on left tonsil and two or three pimples on the right. The cook had just recovered from a sore throat, which had lasted a week. The two servants slept in the same bed.

October 23d, last night the mistress was taken with shivering and sore throat. The tonsils and fauces appeared red and swollen, but there were no pimples.

October 24th, she was sick twice last night. There were two pimples on the left tonsil.

October 25th, felt much better. Pimples gone, redness less.

Herpes, says Mr. Curgenvén, has been divided by Willan, Hebra and Wilson, into herpes labialis, nasalis and præputialis, zoster, iris and circinatus. I can find no mention by these authors of any form of the disease like the one I have described. Hebra remarks, that “an herpetic affection of the skin of the face, the red parts of the lips, and the mucous membrane of the mouth, sometimes occurs in perfectly healthy subjects, being then the only morbid condition which is to be detected; but, in other instances, such an eruption precedes

or accompanies the outbreak of a febrile or non-febrile complaint." Wilson says, "Herpes labialis is sometimes associated with aphthæ of the mouth." These writers do not seem to have ever witnessed such a train of symptoms as are described above. The white spots or pimples are widely different from aphthæ.

Mr. Curgenven seems inclined to attribute the disease to the contagion of the foot-and-mouth disease in cattle, although he was unable to find any diseased cows in the dairy from which his first two patients derived their supply of milk.—*Brit. Med. Journal*.

On the Keloid of Addison and Alibert.—Mr. Hutchinson has had under his care, at the London Hospital, two typical cases—the one, the keloid of Alibert, the other, that of Dr. Addison.

The subject of Alibert's keloid was a girl five years of age, who had been severely burned upon the shoulder, the front of the neck and the upper extremity, and less severely elsewhere. The thickened buttons of indurated tissue, so characteristic of the disease, had appeared upon the cicatrices. Mr. Hutchinson regards the keloid of Alibert as a local affection, a fibroid growth of the cicatricial tissue of burns and scalds and small-pox. The keloid of Addison, he thinks, is a constitutional disease, probably a neurosis, and grows upon healthy integument, never upon cicatrices. There was no analogy between the two affections, except that each presented similar elevated, smooth and pinkish patches of indurated tissue. The keloid of Alibert never contracts, and thus differs from cicatricial tissue, which, by its contraction, causes great deformity. This form of keloid generally sends out irregular outgrowths from the circumference of its patches, and is sometimes troublesome in consequence of its extreme irritability. It is inadvisable to remove the growth by the knife, as it always returns. In Mr. Hutchinson's experience, he has observed a tendency in this form to diminish in extent, and in some cases to disappear altogether. These changes occur more rapidly in some cases than others, and it is a comforting assurance to the patient that the growth will sooner or later disappear. The second case is that of Addison's keloid, which has been also described under the names of *morphoea alba* and *scleroma*. The patient, aged 8 years, presents very markedly, in the lower limbs, the hide-bound condition caused by the contraction of hard, dry, parchment-like integument. These are indurated nodules of the growth, systematically arranged over both

scapulæ. The essential points of difference between this form of keloid and that of Alibert, are its tendency to contraction, its evident dependence upon some constitutional affection, and its frequent distribution along the course of the nerves.—*Lancet*, Jan. 22d, 1870.

Syphilitic Amaurosis.—M. Galezouski read at the Academy of Medicine, of Paris, a paper upon the ocular, orbital and cerebral forms of syphilitic amaurosis. The following are his conclusions based upon the observation of more than ninety cases:

1. Retinitis and syphilitic optic neuritis may exist without alteration of the choroid and the iris; these cases, however, are exceptional, and are characterized by plastic exudations and apoplexies, which differ slightly from other retinites.

2. In the majority of cases, retinitis and syphilitic optic neuritis, are preceded by iritis or choroiditis, or perhaps by the two affections simultaneously. Syphilis alone can give rise to these coincident disorders in the vascular and nervous membranes of the eye.

3. Impairment of the chromatic faculties are constant in retinitis and syphilitic optic neuritis.

4. Syphilitic choroiditis is one of the most frequent forms of syphilitic amaurosis. The signs of this affection are very characteristic and pathognomonic, as had already been demonstrated by the elder Demarres:

- a. Impairment or loss of sight coming on by paroxysm.
 - b. A cloud before the eyes in the form of floating cobwebs.
 - c. Photopsia.
 - d. Photophobia.
 - e. Hemeralopia, at an advanced stage of the disease.
 - f. Preservation for a long time of central vision, with a diminution in the periphery of the field.
 - g. The papilla clouded and muddy (*papille nuageuse voilée*).
5. Pigmentary retinitis at a more advanced stage.
6. Atrophy of the central vessels, with preservation of the rosy tint.
7. Pigmentary retinitis very often is developed immediately after a syphilitic choroiditis.
8. The pigmentary spots are often grouped in circles, as in herpes circinatus.
9. Acquired syphilitic pigmentary retinitis differs but very little from the congenital form, so that it has been, until now, wrongly attributed to congenital causes.
10. Congenital pigmentary retinitis is an hereditary syphilitic affection.

11. Congenital pigmentary retinitis, as well as the acquired form, should be combatted by a mixed syphilitic treatment.

12. Infants born of syphilitic parents should be submitted to an opthalmoscopic examination, and placed upon an anti-syphilitic treatment, as soon as pigmentary retinitis is discovered.—*Archives Générales de Médecine*.

Scleriosis, Scleroderma.—Dr. Hilton Fagge presented to the Pathological Society, of London, a living specimen of this disease. The patient was a woman, sixty-five years of age, who had been ill about a year. The induration commenced in the neck and affected the cheek, arms, back, chest and breast, extending to the umbilical region in a similar manner to that described by Thirial. The woman is of older age than in other described cases. Sensation is not impaired. In front of each elbow-joint is a band of dense tissue, reaching up and down some distance and becoming tense and scar-like when the arm is extended, and was such as described by Addison under the term *morphœa*. Dr. Fagge did not think the disease was allied to leprosy, and that it was different from the disease described by Rasmussen as scleroderma, which was inflammatory. In this opinion Dr. Tilbury Fox coincided, and expressed his regret that the term *morphœa* was not limited to the anæsthetic white patches of true elephantiasis, for it was the application of that term to the white indurated spots that occur in connection with scleroderma, which had led to the confusion, and classing together of different lesions. He thought the cases described by Rasmussen were of the same nature as that exhibited by Dr. Fagge. The minute changes, as given by Förster, Rasmussen and others, seemed to show that the pathological changes, in the two sets of cases, consisted in an hypertrophous growth of the fibro-cellular tissue, and the connection between this and the changes in the lymphatic system seem to be indicated especially by the researches of Rasmussen. The change might be local and limited, as in the so-called *morphœa*, occurring in connection with scleroderma, in which larger tracts, in bands or wide areas, might be affected. The differences, in regard to aspect, were probably dependent upon the varying contractility of the newly-formed tissue.

There was also a case presented, by Mr. Weedon Cooke, of a young woman, the skin of whose thighs hung in loose and hypertrophied folds from the upper part to below the middle. The integuments were of lax feel, very elastic and dark colored. Dr. Fox thought that all these cases might be included in one group.—*Lancet*, Dec. 18th, 1869.

Therapeutical Notes.

Treatment of Diseases of the Skin.—Dr. McCall Anderson divides the treatment of skin diseases into the local, the constitutional and the mixed, or a combination of local and constitutional treatment. He first considers local treatment, and gives the following indications for its use :

1. In Eruptions dependent upon local causes, as scabies.
2. That many Eruptions, originally of constitutional origin, ultimately become mere lesions of the skin, or, as he styles it, that the skin has contracted a bad habit. In these cases local treatment only is necessary.
3. Local Applications sometimes react constitutionally, as mercury and tar, producing salivation and gastro-intestinal disorder, therefore they require care in their use.
4. Local Remedies are not always of uniform action, owing to the condition of the health, the sensibility of the skin, and also to the more or less careful preparation of the remedies.
5. The removal of Crusts and Scales is necessary for a correct diagnosis, and for the more perfect action of topical remedies, which may be done either by saturating with almond oil, and then washing off with warm water, or, if they are very adherent, a poultice of bread crumbs or hot almond oil should be applied, and then the crusts removed by the finger nail, or, if they are upon hairy parts, by a comb. In some cases the solvent action of potash solution is necessary.
6. It is essential to determine whether the eruption is acute or chronic, as the applications suitable to the one condition may be unsuitable to the other, and to ascertain whether soothing or stimulating remedies are indicated.
7. Upon an acutely inflamed Surface, as a copious eruption of vesicles and pustules, if it is accompanied with burning heat and pain rather than itching, local treatment, if it is used, should only be of the most soothing character. An exception to this rule is *tinca sycosis*, in which there is great swelling and pain in the beard, which cease upon forcible evulsion of the hairs, which, being loaded with fungus, act as foreign bodies, and are the cause of the irritation.

8. Soothing Applications are used, either in the form of baths, powders, poultices, ointments or lotions.

9. Baths, particularly when warm and medicated by soda, gelatine or starch, are useful in inflammations of large extent of surface, as acute general psoriasis, in which disease, also, cold packing, after the manner of Hebra, is very beneficial, as it allays the great irritation of the skin. It is necessary, also, that it should be repeated daily. In some cases of acute and chronic eczema, the shower bath is an excellent palliative. The water, which should not be hard or sea water, but rather rain water or spring water boiled and allowed to precipitate, should be very finely divided, fall from the height of about a foot, and be continued on each occasion fifteen minutes, and may be repeated three or four times daily. The patient is to follow each bath by half an hour's brisk exercise.

10. Acute inflammations of the Skin, as erysipelas, shingles, or eruptions attended with moisture, or occurring on surfaces of integument which are in apposition, require absorbent powders of starch, zinc, lycopodium, &c., which are very useful in allaying the attendant burning heat and itching. The following is a favorite prescription, containing camphor, which is an important adjunct :

R—Powdered starch,	3 vi.
Oxide of zinc,	3 iij.
Powd. camphor,	3 ss.
M—Cochineal,	gr. j.

To be kept in a stoppered bottle to prevent evaporation.

11. Where pain or tension exists, or where suppuration is impending, poultices are indicated. But care in their use is necessary, as they often cause eczematous eruptions, and sometimes, when used for boils, favor the development of others in the vicinity.

12. Soothing Ointments are capable of more general application than any of the preceding. They, however, owing to idiosyncrasy, are intolerant by some persons. They soften and hasten the removal of crusts, and form a covering for inflamed parts, and exclude the air from them. Benzoated ointment of oxide of zinc ranks highly, and is capable of very extended use. It can be improved by the addition of camphor, which renders it more sedative. The benzoin which is incorporated acts as an antiseptic, and imparts a pleasing fragrance. Sub-nitrate of bismuth, in the form of ointment, is also a very soothing application, but benzoated lard must not be used in its preparation, as it acts as an irritant when combined with

bismuth. A combination of litharge plaster four drachms, and olive oil three drachms, is very useful when spread on linen and applied in strips to parts which require support, as eczema of the leg. It is not as soothing, however, as the other applications.

13. Soothing Lotions sometimes are very useful to relieve uneasiness, as in eczema impetiginodes of the face, either applied to the parts frequently by sponging, or kept on continuously by pieces of rag saturated. Preparations of lead and soda are probably the best, as in the following prescriptions :

- (a) R—Liq. plumbi subacetatis, 3 i.
 Glycerinæ, 3 iv.
 M—Aquæ, 3 vi.
- (b) R—Acidi hydrocyanici dil., 3 ij.
 Sodæ bicarbonatis, 3 i.
 Glycerinæ, 3 iv.
 M—Aquæ Rosæ, 3 vss.

14. Tarry Applications very much allay the itching of chronic eruptions. They are, 1st, wood tar, *pix liquida*, of which Guyot's solution is very eligible for its solubility and its modified odor, and the fact that it does not discolor the skin ; 2d, Coal tar, *pix mineralis*, of which the *liquor carbonis detergens* of Wright & Co. is a very useful application, which, combined with water, forms a creamy emulsion ; 3d, Oil of cade (*oleum cadini*), the product, by dry distillation, of *juniperus oxycedrus* ; 4th, The *oleum rusci*, of the bark of *betula alba*, or white birch. The last two are preferable to the other tarry preparations, from the fact of their odor being more pleasant and less pungent. As they are expensive, their use is inadmissible in dispensary practice. There are, however, exceptional cases in which the tarry preparations are not beneficial, as they excite dermatitis. When their use is very much prolonged, they produce in all persons an inflammation at the orifices of the hair follicles, in the shape of papules and pustules. In the centre of each is a black plug of tar. This has been called by Hebra *tar-acne*, and, of course, when produced, necessitates a change of treatment. Tarry products may be used either alone or in combination. They should be rubbed firmly into the affected part twice a day, but not to the point of causing pain. The following are very useful combinations :

- (a) R—Guyot's solution of tar.
 Soft soap, 3 j.
 Rectified spirits, aa. 3 j.
 M—Spirits of rosemary, 3 i.

(b) R—Nitric oxide of mercury,	℥i.
Nitrate of mercury ointment,	℥i.
Oil of white birch,	℥iss.
M—Benzoated lard,	℥iv.

They should be washed off before each re-application. Creosote and carbolic acid are also worthy of mention. Creosote, in the form of an ointment, five or ten grains to the ounce, allays irritation of the skin. Mr. Balmano Squire's ointment, formed of creosote two ounces, and white wax one ounce, is sometimes useful in cases of chronic psoriasis, after removal of the scales ; it, however, may prove too irritating. Carbolic acid is preferable to some of the tarry applications, as being more cleanly and of less disagreeable odor. Though, for these reasons, it can be used on exposed and hairy parts in general, it is not nearly as efficient as some of the empyreumatic oils. The following prescription is useful, applied two or three times a day, or when the itching is troublesome in cases of chronic erythema, chronic eczema, &c. ; and, while it allays irritation, it is also directly curative :

R—Acidi carbol. crys.,	℥ij.
Glycerinæ (Price's),	℥vi.
Spt. vini rect.,	℥iv.
M—Aquæ destil.,	℥i.
Make a lotion.	

15. Potash Applications, so prominently brought forward by Hebra, are very useful for the removal of abnormal products, as the scales of psoriasis, &c. They hasten the cure of the eruption by their stimulating effects, especially when combined with other remedies, such as preparations of tar. The most eligible preparations of potash are the potash soap, otherwise called black soap, or *sapo mollis*, *liquor potassæ* and solutions of *potassa fusa*, of varying strength, from two grains to a drachm to each ounce of excipient. The parasitic disease, known as *tinea versicolor*, may readily be cured by scrubbing the whole of the eruption night and morning with black soap, which, besides acting as a stimulant, is serviceable in removing the scales loaded with fungus. The combination of the so-called parasitocides with solutions of black soap is very efficient in parasitic diseases. The following is a useful prescription :

R—Hydrarg. perchlorid.,	gr. xij.
Saponis mollis,	℥iv.
Spiriti rectificat.,	℥ij.
M—Ol. citronellæ,	℥i.

This should be rubbed firmly into the patch night and morning, but not so severely as to cause pain. In chronic eczema the topical applications of potash are very useful ; they allay

irritation, remove morbid exudations, and, by stimulating the parts, favor the removal of the infiltration. They should be rubbed briskly upon the part with a large paint brush or a sponge provided with a handle, until decided smarting and exco-riation result ; then the patch should be washed with water, and a soothing ointment applied to it. If no application be made after this stimulation, the surface becomes covered by a great number of gelatinous drops, which shows how active the process was. It is necessary to wait until the effects of one applica-tion have passed off before repeating it ; but the process must be repeated as long as any infiltration remains. It sometimes is ju-dicious to apply some tarry preparation in conjunction with the potash applications. Hebra's modification of Pfeuffer's treat-ment of chronic general psoriasis, by rubbing soft soap into the whole eruption until slight bleeding is produced, and repeated twice a day for six or eight days, is often very effectual. Dur-ing the time, and a few days subsequently, the patient should lie in a bed enveloped in blankets, after which he takes a warm bath. However, as the treatment is not always successful, and as it is quite painful and necessitates confinement to bed, it is not likely to be generally adopted.

16. Mercurial Applications are not beneficial to the same extent as the preceding. They may sometimes prove beneficial combined with empyreumatic oils, when itching is a prominent symptom. They include corrosive sublimate, calomel, white and red precipitates, red and green iodides of mercury, oint-ment of nitrate of mercury, black and yellow washes, &c. The well-known treatment of syphilitic condylomata by washing twice a day with diluted Labarraque's solution and dusting with calomel is very effectual, as well as most of the mercurial ap-plications in syphilitic affections. In acne and chronic erythe-ma of the face, the following solution, rubbed firmly into the part night and morning, by a piece of sponge or flannel, is very useful :

R—Hydrarg. perchlorid,	. . . . .	gr. xij.
Glycerinæ,	. . . . .	3 iv.
Spt. vini rect,	. . . . .	3 v.
Spt. rosmarini,	. . . . .	3 i.
M—Cocci cacti,	. . . . .	gr. i.
Mix and strain.		

In the treatment of *lupus erythematosus*, and of allied affec-tions, the *emplastrum hydrargyri*, as suggested by Moriz Kohn, of Vienna, is very useful. The part should be covered with the plaster, spread upon lint, and changed each day. In

cases of dry eezema, of psoriasis, and, above all, in dry syphilitic eruptions, the following ointment is of great use :

R—Hydrarg. submuriat,	3 i.
Ung. hydrarg. ammoniat,	3 ii.
Glycerinæ,	3 i.
M—Unguent simplicis q s. ad.,	3 i.

To be used night and morning. It is necessary to remember that mercurial applications are, to a certain extent, absorbed, and hence, particularly when used upon a large extent of surface, or when the patient is not frequently seen, he should be warned of the possibility of salivation.

17. The use of Sulphur, though it cures scabies, is very often the exciting cause of an eezema, or aggravates the eruption for which it is used. But, used with discrimination, it may be of value. In acne rosacea the following ointment is beneficial :

R—Rumex ointment,	3 i.
M—Hypochloride of sulphur,	3 ij.

Rub very firmly into the eruption night and morning, short of producing pain. The rumex ointment is made as follows :

R—Rumex root,	3 xviii.
Prepared lard,	3 xij.
Yellow wax,	3 ij.
M—Distilled water q. s.	

Bruise the roots, boil for two hours, strain and evaporate to four ounces ; add gradually to the lard and wax previously melted, and stir until cold.

Sulphur is useful in acne vulgaris (papular form) upon the face and backs of young persons, in the following prescription :

R—Sulphuris,	3 vi.
Glycerinæ (Price's),	3 vi.
Spts. vini rect,	3 vj.
M—Ol. rosæ,	mi.

Shake the bottle well and rub firmly into the eruption with a piece of flannel, night and morning. In cases of *genuine* prurigo (not the lesion resulting from scratching with the nails), the following preparation of sulphur is very excellent, particularly when combined with any of the empyreumatic oils :

R—Sulphuris,	3 i.
Picis liquidæ,	3 vi.
M—Adipis benzoat,	3 iv.

Rub very firmly into the eruption, night and morning.

Acetate of soda, of a strength of eight grains to an ounce of water, as suggested by Drs. Weisse and Satterlee, has

proved very beneficial in lupus and strumous diseases of the skin. A still stronger solution, twenty grains to the ounce, may be used. Sponge the affected parts three or four times a day, and cover them with rags saturated in the solution, protected by oil silk, at night. Under its influence the crusts fall and the ulcers heal, after which the improvement is slower, and then a more speedy cure generally occurs by substituting some other treatment. The application to the ulcers of the pure crystals is sometimes beneficial; also the injection of the solutions into sinuses favors their closure.

18. Impermeable Dressings, as used by Hardy and Hebra, act by excluding air, keeping the parts warm at an even temperature, promoting secretions from cutaneous glands, which macerates and favors the removal of the epidermis. Cases are detailed proving the efficacy of the mode of treatment. The first is one of palmar psoriasis, of nine years' duration, which was much benefited, and the final cure produced by the benzoated zinc ointment. The second case was an *eczema manum*, of three years' duration, with much infiltration, itching, and tendency to spread. The patient was ordered to wear a pair of india-rubber gloves, and was shortly much relieved. The third case was that of a girl aged four years and eight months, who had scarcely been free from *eczema capitis* since she was eighteen months old. The eruption covered the whole scalp and the ears. There was much redness, infiltration, incrustation and exudation, and the patient complained of great irritation and burning heat. As various remedies had been unsuccessfully used, she was directed to wear constantly an india-rubber cap. The effect was to cause the disappearance of the structural change and allay the irritation. Case fourth was that of a young lady who had the *non-ulcerating* variety of *lupus* attacking the tip of the nose, and a strumous eruption on the toes, associated with several small ulcerations, and covered, for the most part, with thick, hardened epidermis. Under treatment the nose recovered perfectly, and the eruption on the toes improved, but the skin remained very thick and hard. These parts were covered with vulcanized india-rubber, and the thickening entirely disappeared, and the toes had nearly resumed their normal appearance. Case fifth was that of a gentleman 65 years of age, who was afflicted with *pruritus senilis*. As other methods of treatment had failed to give relief, he was enveloped in a complete under-dress of vulcanized india-rubber cloth, and the itching ceased and eruption completely disappeared. This treatment is also useful in cases of *prurigo* and *ichthyosis*, and probably most

of the obstinate local eruptions. It possesses the advantage of not interfering with the simultaneous use of other local applications. The dressings cure even if only used at night, but they act more successfully when continually worn. They should be cleaned occasionally, and the skin wiped, and, should any excoriations occur, they should be dressed with zinc ointment.

19. Caustics are useful in some forms of skin diseases. It is necessary to use care with arsenical caustics, and not apply them over large extents of surface, for fear of fatal consequences from absorption. Fowler's solution sparingly painted upon small patches of epithelioma is very often attended with good result. The application should be made daily, and from ten to twenty drops of the solution used. *Potassa fusa*, in the strength recommended by Hebra (one drachm to two of water), is beneficial in removing the infiltration of chronic eczema. It should be painted upon the part with a large brush, and then rubbed until a lather is produced, by a rag dipped in water, and then followed by cold dressings until the effect has passed off. This should be continued until the infiltration is less, and then the tarry preparation should be used.

20. Nitrate of Silver, in form of points, is very useful when energetically employed in *lupus vulgaris*. The point should be thrust entirely through the morbid tissue until the healthy tissue is reached, and it is not necessary to follow the application with any dressing. When the crust falls it may or may not be necessary to repeat the treatment. Solutions of nitrate of silver, as recommended by Mr. Higginbottom, of the strength of one scruple to a drachm of water, is very efficacious in the treatment of erysipelas. The eruption should be washed with soap and water, and subsequently with warm water, to remove all soap, which would decompose the nitrate of silver, then carefully dried, and then it should be painted with the solution as far as an inch beyond its limits. If on the following day any spots are white, or are not properly covered with the nitrate of silver, they should be thoroughly repainted. Should the inflammation extend, the application should be applied to it; and if blisters are produced by the caustic, they need not be touched, but the bullæ of erysipelas should be opened. When erysipelas attacks the scalp it is best to shave it, if the patient will allow, or at any rate crop-ped. The extension of the disease in the hairy scalp is known by the occurrence of pain and the pitting upon pressure. As it has been noticed that parts affected by lupus, when attacked by erysipelas, have appeared much improved when that efflor-

escence has subsided, M. Hardy proposes, in lupoid patches, to excite an artificial erysipelas by means of a very strong ointment of the *red iodide of mercury* (equal parts of that salt and lead). Though painful, it is sometimes attended with improvement. The application should be renewed when the inflammation produced by a previous one has passed away.

21. The Actual Cautery is another mode of destroying lupus vulgaris, and is less painful than are caustics; but it is thought that the lesion recurs more frequently than after the caustic applications.

22. Blisters are of great value in obstinate circumscribed eruptions, when applied over the spots, not as a counter-irritant in their vicinity. A solution of corrosive sublimate (one drachm to the ounce of alcohol) might be used, but it produces pain and is liable to produce pytalism, so that its use is restricted to circumscribed and very obstinate syphilitic patches. Indolent ulcers are sometimes very much improved by blistering, which, also, when frequently repeated, is very useful in *lupus erythematosus* and *lupus exedens*. There is no remedy more successful than long-continued blistering in alopecia areata, which is sometimes useful in tinea tonsurans. In inveterate cases of circumscribed eczema, blisters sometimes produce astonishing results. When alopecia areata involves the head, or in other obstinate eruptions, the blistering may be used piece-meal, or an ointment of cantharidis, used as follows:

R—Pulv. cantharid, 3 ij.

Adipis præparat,

M—Ung. hyd. iod. rub., aa, 3 i.

Rub this ointment firmly into the patch night and morning, avoiding the production of vesication and pain.

23. Iodine, in the form of ointment or tincture, is useful in the treatment of strumous affections of the skin. In cases of *lupus*, especially the form known as *lupus erythematosus*, the long-continued use of a concentrated solution of iodine and iodide of potassium may effect a cure. The following is a convenient formula:

R—Iodini.

Potassii iodidi, aa, 3 ss.

M—Glycerinæ, 3 i.

Paint the part and repeat daily until a thick red skin forms, or until pain is produced. When the effect of the application has passed off, renew it. The combination of iodine and tar, as proposed by Mr. Carter, is very effectual in ringworm of the

head, though if it produce suppuration its use must not be persisted in. The formula is as follows :

R—Iodini, ℥ ij.
M—Ol. picis liquidæ, ℥ i.

Mix gradually, as otherwise so much heat is generated that the iodine is dissipated. Usually one application is sufficient, but if the case is chronic it may require several.

24. Parasiticides are remedies having the power to destroy animal and vegetable parasites which attack the skin. In phthiasis, or disease due to lice, one of the cleanest and safest remedies is a lotion of corrosive sublimate. For lice of the body, the stavesacic ointment is useful, as follows :

R—Pulv. staphisagreae, ℥ i.
M—Adipis, ℥ ij.
Digest for three hours and strain.

For the treatment of scabies sulphur is objectionable, on account of its irritant qualities, and a solution of chlorate of lime, as proposed by Dr. Christison, is preferable, to be used night and morning ; or styrax ointment, as follows :

R—Styracis liquidæ, ℥ i.
M—Adipis, ℥ ij.
Melt and strain.

To be rubbed on the parts every night for three nights. Schultze's modification of Pastan's prescription is as follows :

R—Styracis liq., ℥ i.
Spts. vini rect., ℥ ij.
M—Ol. Olivæ, ℥ i.

The styrax is an equally efficient parasiticide as sulphur, and does not irritate, but soothes the itching. Besides the vegetable parasiticides already noticed, such as sulphur mercurials and empyreumatic oils, sulphurous acid and hypophosphite of soda are worthy of mention. Sulphurous acid may be used in its purity ; hyposulphite of soda should be used in the form of solution, 30 to 60 grains to the ounce of water. The affected parts, after the removal of epethelial *débris*, should be sponged with the solution two or three times a day. When parasitic diseases attack parts covered with hair, epilation is necessary in addition to local applications. The hairs should be pulled in the direction of their axes, and not more than six grasped at each time. The pain produced by epilation is much lessened by rubbing oil of cade into the parts night and morning, or, what is preferable, lubricating with oil of almonds, which diminishes pain, renders the hair less brittle, and causes

it to grow more healthily. After one complete epilation the treatment should be stopped for a week or so, then followed by partial epilations upon parts where it was insufficiently done. To prevent reinfection of parasitic diseases it may be necessary to either destroy the clothing or disinfect them by exposing them to the fumes of sulphur or hot air, or steeping in boiling water.—*Lancet*, Nov. 20th, Dec. 4th and 18th, 1869, and Jan. 29th, 1870.

Syphilitic Stricture of the Rectum.—Mr. Marshall, of University College Hospital, operated upon a middle-aged woman for a tight stricture of the rectum, very near the anal orifice. There was a clear history of syphilitic affection, which had taken place some years previously. It was remarked that syphilitic ulceration frequently extends backwards from the genitals to the margin of the anus, and in some instances passes into the rectum. Syphilitic disease within the rectum manifests itself in the form of a round ulcer on the posterior surface of the bowel. This round ulcer often spreads laterally, and occasionally to such an extent as to form a narrow annular band of ulceration around the rectum, near the lower end. The condition of the parts which results from cauterization of an ulcer of this kind was well exemplified in the present case. The finger, introduced into the bowel, came first upon a thin, fibrous constriction, above which was a narrow and annular groove, and then another tight constriction, thin and fibrous like the first. Several minute incisions were made into the edges of the strictured portions, and then the narrow portions of the rectum were dilated, first by the finger, next by the expanding blades of a large pair of dressing forceps, and finally by a fair-sized rectum bougie. There was very little hemorrhage. At the same time a hard, freely-movable tumor was removed from the breast. It appeared scirrhus.—*Lancet*, Jan. 1st, 1870.

Sulphurous Acid in Syphilitic Ulcerations.—A woman of advanced age was admitted to Middlesex Hospital, under the care of Dr. Murchison, for extensive tertiary ulceration at the back of throat, implicating very deeply the posterior pillars of the fauces. Iodide of potassium and chlorate of potassa were administered internally, and sulphurous acid locally, both as a gargle (one to four) and in the form of spray. The result was the healing of the ulcer; but when the application was discontinued for three days there were signs of its renewed action, showing that it was really beneficial.—*Lancet*, Jan. 8th, 1870.

Editorial.

IN the last number of the *Annales de Dermatologie et de Syphiligraphie*, there appears the following complimentary recognition of this Journal in France. We avail ourselves of this opportunity of correcting an error innocently committed by our esteemed and accomplished confrère, Dr. Doyon, the editor.

Si les Américains entrent les derniers dans la voie du journalisme spécial, ils ont du même coup dépassé leurs devanciers en créant simultanément, et une société de dermatologie, ainsi que nous l'avons annoncé dans notre précédent numéro, et actuellement, *The American Journal of Syphilography and Dermatology*, édité par le Docteur Henry.

Aux félicitations que nous adressons à nos collègues d'outre océan, nous sera-t-il permis d'ajouter un mot empreint d'un sentiment moins impersonnel? Dans notre précédent article sur les sociétés de dermatologie, nous faisons sentir qu'il est impossible, dans un corps académique comme dans un recueil périodique, de séparer deux spécialités aussi indissolublement liées que le sont la syphiligraphie et la dermatologie. Aussi ne pouvons-nous nous défendre d'une certaine satisfaction en voyant nos honorables confrères qui avaient protesté contra cette union si profitable aux progrès de la science, la réaliser aujourd'hui dès leur premières-sai. Il appartient à l'Amérique de donner l'exemple d'une abnégation aussi digne d'éloges; l'esprit positif qui y prime tous les autres mobiles, ne rend possible qu'à ces heureux démentis, auxquels nous devons aujourd'hui, à côté d'une aussi flagrante infraction infligée à la logique, un pareil monument élevé à la science.

Le premier numéro nous donne en effet le spécimen le plus complet de la manière féconde, pratique et impartiale dont la tâche a été comprise, et dont elle sera assurément poursuivie à l'avenir par nos très-habiles et savants collègues.

In order to correct the misapprehension which our French brethren seem, from the above, to entertain in regard to the sentiment of the Profession in New York on the question of the separability of Syphilography and Dermatology, we would here state, that, as regards ourselves, we are, and always have been, unwilling to entertain for a moment the illogical idea of separating the two in any society or journal. We are quite sure that a large majority of those who have in New York paid most attention to venereal and cutaneous diseases will agree with us. This, we say, notwithstanding the action of the Dermatological Society, and we may add, that undoubtedly a majority of the members of that society, as at present constituted, would express a like opinion with our own.

Bibliography.

A Treatise on Gonorrhœa and Syphilis. By Silas Durkee, M. D. Fifth Edition, with colored Illustrations. Philadelphia: Lindsay & Blakiston. 1867.

Annales de Dermatologie et de Syphiligraphie, publiées Par le docteur A. Doyon. Deuxieme Année, No. II. Paris: Victor Masson et fils. 1870.

Archiv für Dermatologie und Syphilis. Herausgegeben von Dr. Heinrich Auspitz und Dr. Filipp Josef Pick. Jahrgang. 1870. Erstes Heft. Prag. 1870.

The Practitioner; a Monthly Journal of Therapeutics. Edited by Francis E. Anstie, M. D., F.R.C.P. February, 1870. Macmillan & Co, London, and 63 Bleeker St., New York.

New York Medical Journal. Edited by Edward S. Dunster, M. D. March, 1870. New York: D. Appleton & Co.

The Journal of Psychological Medicine. Edited by William A. Hammond, M. D. January, 1870. New York: D. Appleton & Co.

American Journal of Insanity. January, 1870. State Lunatic Asylum, Utica, New York.

The American Journal of the Medical Sciences. Edited by Isaac Hays, M. D. January, 1870. Philadelphia: Henry C. Lea.

The Half-Yearly Abstract of the Medical Sciences. Edited by W. D. Stone, M. D., F. R. C. S. January, 1870. Philadelphia: Henry C. Lea.

Half-Yearly Compendium of Medical Science. Part V. January, 1870. Philadelphia: S. W. Butler, M. D.

California Medical Gazette. Edited by J. D. B. Stillman, M. D., and W. F. McNutt, M. D. March, 1870. San Francisco: A. Roman & Co.

Buffalo Medical and Surgical Journal. Edited by Julius F. Miner, M. D. February, 1870. Buffalo.

The Journal of the Gynæcological Society of Boston. Edited by Drs. Winslow Lewis, Horatio R. Storer, and George H. Bixby. March, 1870. Boston: James Campbell.

The Medical and Surgical Reporter. **The Medical Record.** New York. **The Medical Gazette,** New York. **The Chicago Medical Times.** **The Medical News and Library.** **The Boston Medical and Surgical Journal.**

Foreign books for review may be addressed to the following agents of the publisher, who will forward them immediately:

LONDON—Messrs. Williams & Norgate, 14 Henrietta-street, Covent Garden, W. C.

PARIS—Mr. Cs. Reinwald, 15 Rue des Sts., Pères.

LEIPZIG—Mr. L. A. Kittler.

American books and papers for Review may be sent directly to the Editor, or to care of F. W. Christern, the publisher, No. 77 University Place, New York.

THE AMERICAN JOURNAL

OF

SYPHILOGRAPHY AND DERMATOLOGY.

JULY, 1870.

Original Communications.

ON VACCINO-SYPHILITIC INOCULATION.

BY FRANK P. FOSTER, M.D.,

House Physician to the New York Dispensary.

WITHIN the past six years a great deal has been written about the inoculation of syphilis in the operation of vaccination. Some authorities have treated of the subject very ably, and in a spirit of perfect fairness; others have, in a partisan spirit, advocated or opposed the doctrine of the possibility of conveying syphilis along with vaccinia; and in some quarters the discussion has given rise to no little acrimony.

The question, divested of all side-issues, narrows itself down to this:—*Has syphilis been proved to have been communicated to a non-syphilitic person by inoculation with pure lymph from a typically developed eighth-day vaccine vesicle?* This is a very hard question to answer, and Dr. Ballard¹ well remarks that “The truth lies at the bottom of a sea of difficulties.” In order to its elucidation, let us first consider the *primâ facie* evidence furnished by theory, in the light of which we may then pass on to the consideration of clinical and experimental data.

¹*On Vaccination; its Value and Alleged Dangers. A Prize Essay.* By Edward Ballard, M.D., etc. London, 1868.

I. THEORETICAL EVIDENCE.—This comprehends theories bearing upon the question of how far, if at all, a constitutional disease or diathesis is capable of impressing its own character on the secretions of a lesion not its own; in other words, whether in such lesion there may be generated a virus possessed of the two-fold attributes of both diseases. In seeking for a parallel case to the one under consideration, there can be found none more to the purpose than the simultaneous occurrence of small-pox and vaccinia; and, if the paradox be admissible, the parallelism is enhanced by a certain diversity, viz: that, whereas syphilis is communicable only by actual contact, small-pox may be communicated both by contact and by effluvi-um. Now, in such cases, those of variolous pustules and vaccinal vesicles occurring on the same individual simultaneously, side by side, if we inoculate with the fluid from the vaccinal efflorescence, taking due care that the inoculated person be not subjected to the action of the small-pox virus or effluvi-um, we truly *vaccinate*, *i. e.*, we produce only vaccinia, without a trace of variolous contamination.

But, the following argument, advanced by Auspitz,¹ is still more to the point, and seems to me as convincing as anything short of actual demonstration can possibly be considered: If, in the recorded cases of syphilis following vaccination, the vaccine lymph *itself* conveyed the contagion, syphilis ought to have occurred in *every case* in which the vaccination took effect, because, on the syphilitic-vaccine theory, the contagious element of syphilis must have been as intimately and inseparably connected with the molecules of the lymph as was the vaccinal contagion. But, in point of fact, in all the published instances, besides the individuals who have developed both diseases from the same inoculation, there have been others who have developed vaccinia normally, without acquiring syphilis.

Moreover, the pathological secretions of syphilitic persons, when not those of syphilitic lesions, for instance, the sputum, pus from a suppurating wound, etc., occurring in the subjects of syphilitic disease, have not been shown to be capable of con-

¹*Die Lehren vom Syphilitischen Contagium und ihre Thatsächliche Begründung*, von Dr. Heinrich Auspitz. Vienna, 1866.

veying a syphilitic taint to another individual. Auspitz makes this statement, and I need not add, that it is the belief of most syphilographers that the physiological secretions of syphilitic individuals are incapable of conveying syphilis.¹

Many accomplished pathologists, including Simon, Paget, Hebra, Steinbrenner, and others, have written very ably in allegation of the theoretical impossibility of communicating any other disease than vaccinia by inoculating the pure secretion of a typical vaccine vesicle ; and although it would be unwarrantable to pit such evidence against that of experiment and clinical facts, still, the opinions of these writers are entitled to great weight. Mr. Simon says, that a typical Jennerian vesicle is something which "only one unmodified influence can produce, which no second influence can concur in producing, and in the contagion of which no second principle of infection can possibly reside." Mr. Paget thinks that "any modification of the lymph, by mixture of another virus, would be indicated by a corresponding modification of the vesicle," and although the opinion has been extensively held, that a syphilitic person is incapable of developing a typical vaccinal vesicle, I am thoroughly convinced from my own experience that this is erroneous. I have produced typical vaccinia in as large a proportion of syphilitic individuals, as of those free from syphilitic taint.

It has been thought that the syphilitic and the vaccine viruses, if inoculated simultaneously, could not both prove effective, for the reason that the syphilitic virus would, as it were, overpower the vaccine, rendering it inert. But, even if true, this would be irrelevant, for it would not hinder the conveyance of syphilis, although preventing vaccinia, and syphilis

¹ In the discussion at the French Academy of Medicine on M. Depaul's *Projet de Rapport*, M. Trousseau quoted in opposition to this opinion the case of a Parisian peritomist, who had infected a large number of Jewish children with syphilis by sucking the wound made in circumcision, and in whose mouth M. Ricord was unable to detect any syphilitic lesion. But this case proves nothing, for, (1) a lesion may have existed, though undiscovered, and (2) almost any mouth may be made to furnish blood by the simple act of suction, and the blood of a syphilitic person is admitted to be capable of conveying the contagion of that disease, although *not readily*.

developed alone is just as disastrous, and just as truly the event argued against, as is its development in conjunction with that of vaccinia. But it is not true, as Sperino's experiment, to be hereafter quoted, proves.

Steinbrenner¹ puts the case too strongly in saying that it would be just as absurd to entertain the possibility of conveying syphilis in vaccination, as to hold that of conveying vaccinia by inoculating chancreous pus from a person who should happen at the time to have vaccinia vesicles; for vaccinia is inoculable only from its own lesion, whereas syphilis is inoculable through the medium of the blood.

Theoretical considerations, then, furnish the strongest possible *primâ facie* evidence against the possibility of syphilis being conveyed in inoculation with the pure secretion of a typical vaccine vesicle, and they fully warrant the most rigorous scrutiny of all the facts in alleged cases.

II. EVIDENCE FOUNDED ON CLINICAL OBSERVATIONS.—An examination of the recorded cases of alleged conveyance of syphilis by vaccination, and the application to them of a few simple tests, will show that, rare as those cases are,² scarcely any of them approximate to a decisive character. Before en-

¹ *Traité sur la Vaccine, &c.* Paris, 1846.

² The observations usually referred to by writers on the subject, together with some others of recent occurrence, of most of which only the slightest mention need be made, amount to about forty in number. This number is, it will be seen, exceedingly small, when it is considered how many millions of people have been vaccinated, and that, too, in many cases, with very little in the way of precautionary measures taken against the fortuitous contamination of the vaccine virus with other substances. Almost all the alleged cases have occurred on the continent of Europe, especially Southern Europe. Dr. Ballard declares that he cannot accord *probability* to any case reported as having occurred in Great Britain, and I have yet to see an account of any American case that might be said to fulfill the most important conditions. As far as my own experience goes (comprising some eight thousand vaccinations) I have never known an instance in which the slightest suspicion of syphilitic infection has been raised. This, as far as I can ascertain, has been the uniform experience at the New York Dispensary, which, since its foundation in 1790, has furnished vaccination to upwards of 130,000 individuals.

tering upon the consideration of the individual cases, let us briefly state these tests.

Any case of alleged vaccino-syphilitic inoculation, then, before it can be looked upon as bearing upon what we have stated to be the real question at issue, should fulfill the following requirements :

1. The details of the case should be fully stated.

2. The vaccine virus employed in the vaccination should be shown to have been taken from a characteristic vaccine vesicle, and not to have been fortuitously mixed with any syphilitic secretion (or with the blood or any other fluid from the vaccinifer, or any other person not proved to be free from syphilitic taint) before having been used in the vaccination.

3. The vaccination should be shown to have been done in a cleanly manner, with an instrument which had never been used for any other purpose, not even recently in any other vaccination.

4. It should be stated whether the vaccination was done by the arm-to-arm method, or with preserved virus, and, if the latter, whether with the crust or with lymph, and, if with lymph, in what way and for how long a time the lymph had been preserved.

5. The disease supposed to have been conveyed should be proved to be syphilis, and to have commenced at the place of vaccination by the development of the initial lesion of syphilis, after the lapse of the minimum period of incubation usually observed in cases of syphilitic contagion.

6. The vaccinated person should be proved not to have been tainted with syphilis previously to the vaccination, to have been born of parents always free from such taint, and not to have been so circumstanced as that by any possibility he could have acquired syphilis in any other way than by the vaccination, nor to have been vaccinated from a person in whose vesicle syphilitic virus may have been implanted.

Some of these requirements may be looked upon as refinements, but let it be remembered, that we are not seeking to apply them to the broad question of the communicability of syphilis in the operation of vaccination, but only to the above-

stated question of such communication by means of the *pure secretion* of a typical vaccine vesicle. Still, as Dr. Ballard observes, it is not fair "to ask more of the observers than can be expected to be ascertained."

Bearing in mind the laws of syphilitic contagion, let us inquire how far the reported cases of alleged vaccino-syphilitic inoculation will bear the above tests.¹

I. ROWLEY'S CASES.²—In the first decade of the present century, when vaccination was yet in its infancy, there were in the medical profession many violent opponents of the practice, and among them Benjamin Moseley and W. Rowley. The latter is said to have published meagre details of 504 cases of eruptive disease occurring after vaccination, which he considered to be a new disease, and to which he gave the name of *cow-pox itch*. The disease was preceded by prolonged ulceration at the place of vaccination. Some of these cases seem to have been contagious. Viennois quotes one instance in which it was communicated to the mother's breast. Rowley treated his cases successfully with mercury and sulphur.

II. PITTON'S CASES.³—In 1838 a child æt. fourteen months, described by its parents as having always previously been healthy, was vaccinated. On the sixth day thereafter, a phlysaciôus pustular eruption appeared over the body, beginning at the punctures, and left sharply-defined ulcerations with a greyish bottom. The parents attributed the disease to the vaccination, although many other children in the same parish had been vaccinated at the same time, with the same virus, without any unusual effect. M. Pitton diagnosticated syphilis. In spite of appropriate treatment the child died.

¹ As only a portion of the cases can be given in the present number of the JOURNAL, I purposely begin with some of the weaker ones, reserving the more important ones for the continuation of this paper in the next number of the JOURNAL.

² Not having had access to the original account of these cases, which are generally spoken of as Moseley's, I here attribute their first publication to Rowley, on the authority of Bouvier, who quotes a French translation of Rowley's book with the title of *De l'Inefficacité et des Dangers de la Vaccine*, Paris, 1807. Viennois and Auspitz impute them to Moseley, the former quoting Moseley's *Treatise on the Lues Bovilla or Cow-Pox*, 2d edition, London, 1805. Some other writers profess to quote them from Moseley's *Medical Tracts on Sugar, the Cow-Pox, etc.*, 2d edition, London, 1804. This last work certainly contains nothing of the sort, being a mere diatribe, as Seaton says, against vaccination. Auspitz gives the date of their publication as 1807, which is that of the French translation of Rowley's book.

³ *Jour. des Connaiss. Méd.-Chir.* Dec., 1844. Auspitz erroneously leaves it to be inferred that these two children were both vaccinated at the same time.

Subsequently another child, æt. thirteen months, born of the same parents, was vaccinated. After the same length of time, the child was affected with numerous pustules, and a large patch of so-called lupus. This child rapidly and completely recovered under treatment by the application of strong mercurial ointment on pledgets of lint.

III. OTTERSON'S CASES.¹—These cases occurred in an Indiana regiment, in 1862. The virus used in all of them, so far as could be ascertained, was a crust from the arm of a man who had been revaccinated during convalescence from typhoid fever and pneumonia, and who was absent on furlough during the incubation of his vaccinia. "The disease [in this convalescent] was tardy and irregular in its progress, and he had, after it healed, . . . some rheumatic trouble; almost entire loss of power in the arms; had no skin disease, or night-pains." From this source three hundred persons belonging to the regiment were vaccinated, of whom only eighty had vaccinia. Nearly all of these eighty had symptoms more or less like the following: Local effects tardy, commencing from the 35th to the 51st day, and accompanied with rheumatic pains or lameness in the joints, mostly on the same side of the body with the vaccinated arm, with evening exacerbations in some cases. Some had febrile movement, intermittent in a few of the cases. "Spinal irritation," and enlargement of the cervical glands are mentioned in some of them. Most of them had "sore-throat, but nothing to indicate that it was specific; many of them had skin disease," all of so mixed a character as to throw little or no light on the character of the disease—some scaly, some vesicular. Scanty details are given of nine of the cases. Between the time of the vaccinations and the outbreak of this disease, the regiment had marched about three hundred miles, the weather being very rainy, and the mud and streams very deep. Most of the affected men are described as not having previously suffered from rheumatism or syphilis.

IV. SOLOMON'S CASES.²—Mr. J. V. Solomon stated before the Birmingham and Midland Branch of the British Medical Association, that two cases only had come under his observation, in which there were grounds for a suspicion that syphilis had been conveyed by vaccination. In each the sex was female, and the ages at which the vaccinations were performed, were 16 and 18 years respectively. In one, the scalp, face, and body were stated to have been the seat of an eruption, which, from the description given, and the cicatrices observable, he concluded to have been rupia. In this girl a well-marked syphilitic tubercle followed the excision of a bit of iris. In the other patient, the hair fell off in the course of twelve months after the vaccination, and, in eighteen months subsequent to it, "boils," which commenced on the labia pudendi,

¹ "Can Syphilis be propagated through Vaccination?" By W. C. Ottersson, Surgeon U. S. V. *American Medical Times*, June 6, 1863.

² *Brit. Med. Jour.*, Dec. 11, 1869.

affected the body for two years; "they discharged like ordinary boils." The sight failed two and a half years after the vaccinal punctures were made. The use of atropia proved that the irides had been inflamed, and an ophthalmoscopic examination revealed changes of the choroid in the neighborhood of the yellow spot of each eye.

V. WHITEHEAD'S CASES.¹—Dr. Whitehead observed, in the period of time from Jan. 1, 1856, to Oct. 31, 1858, among 2584 children, 63 cases of constitutional syphilis, of which 34 were attributed to vaccination, but of which only 14 were by him considered to have thus originated. The particulars of these cases, incompletely given, are as follows:

CASE I. (*Whitehead's second*).—An infant *æt.* nine months, of a bad habit of body. Vaccinated spots unhealed at the end of five months, presenting well-formed rupia, with excavation. General symptoms, copper-colored blotches, a mixed eruption on the face and scalp, extreme irritability of the whole surface. Parents described as apparently healthy.

CASE II. (*Whitehead's eighth*).—An infant *æt.* 11 months, of bad habit of body. Vaccinated at the age of one month. Afterwards had roseola, flat mucous tubercles around the anus, great emaciation, "syphilitic pallor." Relapses after nine months' treatment; mucous tubercles, diarrhoea, retarded development. The father denied venereal antecedents. Mother died of puerperal fever one week after delivery.

CASE III. (*Whitehead's tenth*).—An infant *æt.* 23 months. Father said to be healthy; mother apparently healthy. Vaccinated at the age of four months. Immediately followed by eruption on face, neck, and ears; parotid abscesses on both sides; intertrigo; then "chancrous ulcers" on pudendum; purulent discharge from vulva.

CASE IV. (*Whitehead's eleventh*).—An infant *æt.* 11 weeks, of medium habit of body. Father said to be healthy; mother feeble, but apparently free from taint. Vaccinated at the age of two months. Roseola appeared in 12 or 14 days, mucous tubercles nine weeks afterwards, while under treatment, atrophy four months later. When seen, there were two deep ulcers, with hardened bases, where the vaccine vesicles had been formed three weeks previously; copper-colored roseola on the nates and chin; sallow complexion; mucous tubercles around the anus; eruptions and intertrigo behind the ears; coryza, atrophy, and dysentery.

CASE V. (*Whitehead's fourteenth*).—An infant *æt.* seven months, of bad habit of body. Father, "a man of character and probity," denied venereal. Mother apparently free from taint. Child stated to have been

¹ *Third Report of the Clinical Hospital, Manchester, 1859*

healthy until vaccinated, at the age of three months. Vaccinial vesicles "angry and festered," followed by blotches and wasting. When seen, ulcerative erythema of breech and nates, and psoriasis of anus; thighs covered with serpiginous copper-colored blotches; syphilitic pallor, senile expression, great atrophy, stomatitis erythematosa, husky voice.

CASE VI. (*Whitehead's thirty-first*).—An infant *æt.* 15 months, of bad habit of body. Health of father unknown. Mother apparently healthy. Symptoms appeared "soon after" vaccination, at the age of three months. When seen, serpiginous psoriasis on thighs, breech and hands; atrophied; chronic bronchitis, with suspicion of tubercles.

CASE VII. (*Whitehead's thirty-fifth*).—An infant *æt.* three months, of bad habit of body. Father not examined. Mother apparently healthy. Vaccinated at the age of four weeks. When seen, copper-colored blotches all over the body, most thickly on the nates, ulcerated near the anus (consisting of maculæ, papulæ and psoriasis); aphonia, otorrhœa, atrophy.

CASE VIII. (*Whitehead's thirty-sixth*).—An infant *æt.* 11 months, of good habit of body. Father and mother healthy. Vaccinated at the age of four months. When seen, eczema of entire scalp, face, arms, etc.; free intervals of skin were of syphilitic sallowness, minutely wrinkled, furfuraceous; cervical adenitis. Husky voice, chronic laryngitis. Vaccination had been repeated, under the belief that it would remove what the first seemed to have caused.

CASE IX. (*Whitehead's thirty-eighth*).—An infant *æt.* 11 months, of bad habit of body, healthy previous to vaccination at the age of six months, soon after which, blotches appeared. Father "a man of probity," etc., denied syphilis. Mother "said to have been healthy." When seen, eczema of scalp and face; scattered copper-colored, hard tubercles over the whole body and limbs; inguinal adenitis; atrophy; vomiting and diarrhœa; ulcerated tubercle of right labial commissure; husky voice; cracked psoriasis around the anus; syphilitic pallor.

CASE X. (*Whitehead's fortieth*).—An infant *æt.* 10 months, of medium habit of body. Father and mother healthy. Vaccinated at the age of six months. When seen, syphilitic pallor and œdema of face; dry, cracked ulceration of eyelids, nostrils and lips; a dark, scaly, ulcerated patch in left axilla; inguinal intertrigo; soreness of vulva; bronchitis.

CASE XI. (*Whitehead's forty-ninth*).—A child *æt.* 11 years, of good habit of body. Parents healthy. Stated to have been healthy until vaccinated, at the age of four months, which was followed by deep ulcers and erysipelas, which persisted for six weeks. A year later, syphilitic eruptions on scalp, glandular abscesses in neck, and blepharitis, which lasted two years. When seen, sore throat, husky voice, nocturnal pains of limbs and head, rigors.

CASE XII. (*Whitehead's fifty-sixth*).—An infant *æt.* seven and a half

months, of good habit of body. Father said to be healthy. Mother apparently healthy. Vaccinated at the age of two months. Vesicles degenerated into ulcers, surrounded by erythema. When seen, erythematous blotches, of a copper color, on chest and neck; eczema auris; arthritis of left elbow; herpes tonsurans; syphilitic pallor.

CASE XIII. (*Whitehead's fifty-seventh.*)—A child æt. three years and three months, of good habit of body. Stated to have been healthy until vaccinated, three months previous to being seen. Parents apparently healthy. Vaccinated spots degenerated into three deep ulcerations, with hardened bases, which remained open two months. When seen, there were all over the trunk and limbs flat herpetic-like crusts, with large erythematous areolæ of copper tint, most numerous on the thighs, the cicatrices of the first-formed patches being of a deep copper-color. Great prostration, inappetence, enuresis, dysuria, erythema of the vulva without discharge; chronic blepharitis and photophobia; syphilitic pallor.

CASE XIV. (*Whitehead's fifty-eighth.*)—An infant æt. 15 months, of medium habit of body. Parents apparently healthy. Child healthy until vaccinated, at the age of $3\frac{1}{2}$ months. Symptoms had continued to increase until seen, when there were lichen syphiliticus, syphilitic pallor, copper-colored erythematous blotches on back and chest, a flat tubercle on the left cheek; atrophy.

Dr. Whitehead gives elsewhere¹ a case occurring in his own practice. It may be condensed as follows:

He was asked to vaccinate a child from the arm of another child selected by the parents of the first. The vaccinifer showed erythematous blotches, but they were not at the time recognized as syphilitic. On the ninth day "the vesicles were unusually large; each sore (*sic* [Ballard]) was surrounded by deep and extensive inflammatory hardness," with extensive redness, and enlargement and tenderness of axillary glands of both sides. About the 12th or 14th day there were deep, broad ulcers, with extensive induration; swelling in right axilla very large, and disposed to suppurate. On the 20th day it was opened, and discharged a large quantity of offensive matter. The vaccinated spots were angry-looking, excavated ulcers, of chancreous aspect, with no apparent tendency to heal. There were copper-colored blotches on the skin; mouth inflamed and excoriated, and appeared to have communicated a similar lesion to the mother's nipple. The vaccinifer being now suspected to be syphilitic, simple treatment was exchanged for mercurial inunction and hyd. cum cretâ, apparently with temporary benefit. The elbow-joint soon became inflamed and swollen; several periosteal swellings appeared on the right shin, one of which suppura-

¹ "On the Transmission from Parent to Offspring of some Forms of Disease," &c. 1851, p. 174.

ted, and never healed, the subjacent bone being extensively denuded. The child died at the age of about $4\frac{1}{2}$ months.

The vaccinifer was found to have suffered soon after birth from purulent ophthalmia, and blotches on the skin. Its mother was said to have had gonorrhœa, of which she believed herself cured. Subsequent history of the family not ascertained.

The mother of the vaccinated child died three years later of cancerous disease of the uterus and appendages, preceded by inflammation of the nipples, with lymphangitis, a large axillary abscess; roseola of long duration; rheumatic pains, with nocturnal exacerbations; urethral irritation; inflammation of the vagina; plentiful sanious leucorrhœa, &c. Her husband died of tubercular phthisis a short time before the decease of his wife.

VI. ALPHONSE GUÉRIN'S CASE.¹—M. Guérin, Surgeon to the Lourcine Hospital, presented to the French Academy of Medicine, in the summer of 1869, "a little girl whom he declared to be the subject of vaccinal syphilis—one of some 40 children who were vaccinated at the same time. Two out of three of the punctures which were made followed the normal course. The third was followed by a large, deep, excavated ulcer, with a deeply indurated base. It was accompanied by roseola and glandular engorgement. The child was also said to have had variola eight or ten days after vaccination. In some days' time the chancre and induration disappeared, and, indeed, had done so before M. Guérin saw the patient; but they have been followed by soft condylomata (*plaques muqueuses*) of the vulva, with characteristic ganglionic engorgement. In Mr. Guérin's opinion, there can be no doubt that this child is the subject of syphilis, and that the primary accident was produced at one of the points punctured; but whether the contamination was produced by the lymph employed, or occurred subsequently, he cannot affirm, although in this latter case the short period of incubation becomes still more difficult of explanation. A great number of the members present, however, protested strongly against M. Guérin's conclusions, seeing in the child no signs of syphilis, and only the results of dirt and carelessness. As the child had not been as yet submitted to any specific treatment, they requested that this might be abstained from, anticipating a speedy cure without its aid."

VII. MARCOLINI'S CASES.²—These cases occurred in 1814. They may be most conveniently described in three series:

(1) A child named Catterina Scilibino, two and a half months old, was vaccinated, and developed normal vaccine vesicles. The form and source of the virus employed are not mentioned. In a few days she

¹ *Gaz. des Hôp.*, July 15, 1869. Quoted in *Med. Times and Gaz.*, July 24, 1869.

² *Sulle Complicazioni della Vaccina*. Milan, 1823. *Annali Universali de Medicina, compilati da Annibale Omodei*. Milan, 1824. Auspitz, *op. cit.*

became covered with pustules (on the vulva, the anus, the neck, the trunk, and the mouth), and died in a few months. Omodei states that her parents were syphilitic, and it is certain that she communicated syphilis to her nurse, who in turn imparted it to her own child.

(2) Ten children were vaccinated from Scibino's arm. They became affected with pustules, ulcers, and condylomata, and infected several nurses, and their brothers and sisters. Five of them died in a few months.

(3) Thirty children were vaccinated from the above-mentioned ten. Only seven of them were the subject of subsequent observation. Of these seven, two fell ill, and one of these two communicated disease to the other members of its family. They were affected with pustules, ulcers, and condylomata.

VIII. CERIOLI'S CASES.¹—In 1821 a female foundling, æt. three months, named Martha, apparently healthy, was vaccinated from another child described as previously in good health. Martha's vaccinia was regular, and from her arm forty-six children were vaccinated, but in only six of them was vaccinia produced. From these six, one hundred other children, who had not previously shown signs of syphilis, were vaccinated. In almost all of these one hundred, after the falling off of the vaccinal crusts, sores with strongly adherent crusts, or indurated ulcers, appeared at the place of vaccination. Subsequently they had sores in the mouth, and on the genitals, crustaceous eruptions on the hairy scalp, copper-colored spots, ophthalmia, and pains in the glands and bones. The disease was communicated to nurses and mothers in the form of sores on the breasts. The vaccinator felt called upon to report the facts to the Sanitary Commission, which appointed a committee of investigation, of which Cerioli was secretary. The children and nurses were recognized as suffering from syphilis, and were subjected to hospital treatment—corrosive chloride of mercury internally, with mercurial inunctions. Nineteen children died, and the rest were long affected with great weakness of the lower extremities. One woman died in consequence of a miscarriage, at the seventh month; another miscarried at the fifth month, but recovered.

IX. THE MORBIHAN CASES.²—The statements in this case are on the

¹ First published by Barbantini, of Lucca, in his work *Del Contagio Venereo*, etc., 1821. Subsequently by Omodei, *op. cit.*, Vol. XIX., and again in the *Revue Médicale*, Vol. III., 1845, with a criticism by M. Lepileur. Cerioli responded to the criticisms of Lepileur and Gamberini, in a letter—*Della Possibilità di Comunicare la Sifilide col mezzo della Vaccinazione*, addressed in 1846, to Dr. Luigi Mazzetti. Viennois adopts the authority of this letter and another addressed to himself by Cerioli. Auspitz follows the account of Omodei. Dr. Ballard gives a very incorrect version of the affair. The account here given is compiled from Viennois and Auspitz.

² *Bull. de l'Acad. de Méd.*, tome XXXII., Nov. 13, 1866. *Med. Times and Gaz.*, Nov. 24, 1866. Berkeley Hill, *Syphilis and Local Contagious Disorders*. London, 1868.

authority of MM. Depaul and Roger, who made a report on the matter to the French Academy. On the 20th of May, 1866, a midwife, residing at Grandchamps, obtained some vaccine lymph from the *Préfecture* at the neighboring town of Vannes. With this vaccine, on the next day, she vaccinated two children, in neither of whom was syphilis produced, although they both had vaccinia regularly. On the seventh day she successfully vaccinated from one of these children a third child, who also remained healthy. On the 3d, 4th and 5th of June, she took this child to various *communes*, and vaccinated eighty children from its arms. Forty-two of these were inspected by M. Depaul, who found thirty-nine of them suffering from syphilis. In most of them the point of vaccination was indurated and ulcerated. From two of these thirty-nine syphilitic children, between fifty and sixty others were vaccinated, of whom seventeen were inspected, and fifteen found to be syphilitic. M. Depaul regarded the lymph from Vannes as the original source of the mischief.

Most of the cases thus far given need claim very little comment, as they only serve to show what loose statements of facts have been made use of to prop up the doctrine of so-called *vaccinal syphilis*.

Rowley's cases may be dismissed with the remark that they are too insufficiently described to be of any weight. Their very number is against them. Some of them may have been cases of syphilis, communicated in vaccination, but the operation was very negligently performed in those days, and it need occasion no surprise that a professed opponent of the measure should have been able to collect a large number of cases of bad result. Besides, there are only two reasons—and those very insufficient ones—for allowing that syphilis was present at all, viz: that the patients recovered under a mercurial treatment, and that in one of the cases some sort of disease subsequently appeared on the mother's breast.

In Pitton's cases, it is very evident, that the children, belonging, as they both did, to the same family, were born with a syphilitic taint, the manifestation of which was perhaps hastened by the vaccinal fever. Certainly, syphilis was not conveyed to them in vaccination, for there is no history of the syphilitic initial lesion, and there was not time for the incubation of inoculated syphilis before the appearance of constitutional symptoms. The power of vaccinia, as well as of several acute diseases, to hasten the development of inherited syphilis

has been particularly maintained by Viennois, and is generally allowed.

Otterson's cases are very candidly stated, but it is very evident that Dr. Otterson himself was not convinced even that they were cases of syphilis. Surely they were not cases of vaccinia. If the crust with which the vaccination was performed, possessed any vaccinal energy, which is much to be doubted, certainly it was one of which no judicious vaccinator would have made use. As to the nature of the disease in these cases, although such a question is foreign to the present purpose, the conjecture may be hazarded, that it was one of the various and not well-understood phases of purulent (or kindred) infection.¹

Moreover, these cases, in common with Solomon's, are open to an objection thus stated by Mr. Solomon:—"Inasmuch as both these patients were of sufficient age, at the time of their vaccination, to contract syphilis through an impure sexual intercourse, I am unable to look upon them as satisfactory examples of vaccinio-syphilis." How weighty this objection is, will become more apparent farther on, when we come to the consideration of M. Trousseau's case.

Whitehead's cases (especially his 8th, 10th, 31st, 35th, 36th, 38th, 40th, 49th and 58th), are most pitifully devoid of facts on which to found his deductions. He seems to have been very ready to accept the statements of the parents in regard to their innocence of venereal disease. In only five of his cases—*i. e.*, of those published in the Hospital Report—is any mention made of anything which might be inferred to have been a syphilitic initial lesion, and in only two of these was the lesion witnessed by himself. His description is not at all conclusive in regard to their chancreous nature, and there is not the most desirable amount of certainty in regard to the character of the constitutional symptoms. Admitting their syphilitic character, we are not told of the circumstances of the vaccinations,

¹ See Paget's article on *Chronic Pyæmia*, in *St. Bartholomew's Hosp. Rep.*, Vol. I., 1865; also, Savory's experiments, related in an article in the same volume, entitled *Local Effects of Blood-Poisoning, in Relation to Embolism*.

and extraneous sources of syphilis are not eliminated. In the case which Dr. Whitehead more fully describes, there is very little to indicate that either the vaccinated child or the vaccinator was at any time syphilitic, and certainly the mother of the former did not take syphilis from her child, for there is no history of initial lesion, even of the non-ulcerating variety.

In Alphonse Guérin's case, the opinion of the dissenting members of the Academy was probably correct, as no subsequent mention of the case seems to have been made.

In regard to Marcolini's cases, there is such a paucity of facts, that there is little to be said of them, except (1) that Catterina Scilibino was manifestly syphilitic before her vaccination; (2) that, in the cases of the ten children vaccinated from her, the absence of any account of initial lesion of syphilis leaves us at liberty to assume several methods by which they may have acquired the disease (premitting the question of inheritance, which is scarcely plausible, in view of the fact that *all the ten* were infected), which various methods of infection will be considered in treating of subsequent cases; (3) that the same remark applies with still greater force to the case of the two out of thirty children of the third series, who showed signs of syphilitic disease after vaccination.

Cerioni's cases are, for the most part, satisfactorily described, but there is one important omission, viz: the subsequent progress of the vaccinator, in respect to whether or not she developed syphilis. This fact authorizes us in this case, as in that of Marcolini, to postpone the task of pointing out the probable source of the infection until we come to the discussion of cases containing fewer elements of uncertainty.

In the Morbihan cases, M. Depaul imputes the origin of the infection to the lymph obtained from the *Préfecture*. Of all the cases thus far quoted, this is the first one in which *stored virus* has been charged with conveying syphilis. In this particular instance, the fact that the two children first vaccinated, as also the one next vaccinated, escaped syphilis, is a strong argument against M. Depaul's opinion, although it is barely possible, as suggested by Dr. Ballard in speaking of another case, that syphilitic virus may be implanted along with vac-

cine, and, lying unabsorbed in the vesicle subsequently formed, may again be conveyed to another person, the intermediate vaccinifer continuing healthy. It is scarcely to be admitted, however, that this should occur in two successive removes, as it must have done in this case, to justify M. Depaul's conclusion. But, leaving this consideration out of account, there remains the question as to the possibility of conveying syphilis by inoculation with *stored* syphilitic virus. On this point Prof. Boeck, of Christiania, who, in the practice of syphilization, must certainly have had the most ample opportunity of becoming acquainted with facts pertaining to the inoculability of syphilis, writes as follows:¹ "If syphilitic virus, in a fluid condition, be kept for six or eight days, it is usually no longer inoculable, and, when in a dry condition, it loses its infecting power still earlier. I have grounds for assuming that after the lapse of a few hours it is no longer inoculable." And Sigmund,² writing in 1865, stated that, up to that time, all the cases of the conveyance of syphilis by vaccination had occurred when the operation had been performed from arm to arm, while no instance had ever followed vaccination with the lymph furnished by the vaccination department of the Vienna Foundling Hospital.

In all probability, then, the source of the infection in these Morbihan cases, was in one or more of the vaccinated children themselves, which method of multiplied infection will be more fully discussed in the succeeding portion of this paper. †

¹ *Archiv. für Dermatologie und Syphilis*, No. II., 1869.

² *Wien. Med. Wochenschrift*, quoted in *Med. Times and Gaz.*, March 4, 1865.

ON CONGENITAL SYPHILITIC PEMPHIGUS.

BY CHARLES C. LEE, M.D.

Physician to the Charity Hospital, &c.

UNDER the title of a "Contribution to the Study of Congenital Syphilis," there appeared in the first number of this Journal a short but admirable article from the pen of Dr. Van Buren.

In the same spirit and with the same object as prompted that paper—namely, to furnish the details from actual practice upon which wider generalizations may hereafter be built—I venture to offer the following observations upon one of the rarer manifestations of inherited syphilis.

The symptoms of non-specific infantile pemphigus are so accurately and uniformly described in the text books on dermatology that no repetition is necessary here. One point, however, may be noted; that the generally received statement that pemphigoid bullæ, either of the specific or non-specific variety, are confined to the palmar and plantar surfaces of the extremities, is by no means invariably true.

I have myself notes of two cases of pemphigus in infants in which the eruption covered the neck, face, and upper extremities; while in the third instance of a gentleman, still under my observation, the disease was as fully marked on the wrists and back of the hands as on the palms. That the general development of pemphigus, over the entire body that is, may also occur in the syphilitic variety of the disease, is shown by the following case:

Mrs. J. L., aged 20, came under my care in November, 1869, with the following history. She was married in 1865, and, becoming pregnant, miscarried at the third month without assignable cause.

In a year and a half she again became pregnant, and at the

eighth month gave birth to a stillborn child showing no cutaneous marks of disease. This occurred while nursing her husband through an attack of illness in Cincinnati, and the premature birth was attributed to the fatigue she underwent in that duty. She denies having ever had any skin eruption or ill health of any kind.

When she applied to me in the sixth month of her pregnancy her appearance was healthy, although perhaps a little anæmic: the urine was normal, the foetal movements distinct, and nothing calculated to cause anxiety existed, except the failure to carry her other children to term. The husband had suffered from some malarial fever in Cincinnati, which was followed by a number of boils in different parts of his body, supposed to be due to his exhausted condition. This was the only illness he had ever had, and he certainly looked the picture of health and muscular development, but a careful examination showed that in the winter and spring of 1863 he had contracted chancre, followed in three months by a roseolous eruption, for which he underwent mercurial treatment in New York and Baltimore. He cannot tell what preparation of inureury he took, but it caused no salivation, and his venereal symptoms passed off so completely that he felt no doubt of his entire recovery before his marriage. No syphilitic manifestation of any kind sufficient to attract his attention has occurred since that time, and no glandular enlargement, &c., now exists.

On February 21st, 1870, Mrs. F. was confined at full term, and, after a labor of seven hours, was delivered (without assistance) of a well-grown child. There had been a slight tendency to prolapse of the funis, which was kept up with difficulty, and the expulsive stage of the labor was somewhat prolonged. The child was semi-asphyxiated, and showed so little vitality that the cord was not severed until the placenta had been detached. My attention was at once attracted by what seemed a pustular eruption covering the entire body, but which, on closer inspection, proved to be a crop of large bullæ, filled with sero-purulent liquid. These were most perfectly developed on the arms, hands, and on the lower extremities below the knees, the feet and toes being thickly covered. Two or three

perfectly formed bullæ also existed on the neck and face, and several on the chest and abdomen, but none were found upon the back. A few of the smaller bullæ were confluent, forming dumb-bell shaped blisters nearly a quarter of an inch in diameter, and were surrounded by a violet-colored circle, which contrasted distinctly with the pink skin beyond them; around some of the larger bullæ this marginal circle was quite livid. Here and there a large bleb had ruptured, and through the collapsed epithelial wall could be seen the superficial ulceration of the dermis; no deep ulceration existed. The child's extreme debility continued after free respiration had been established, and it was only by vigorous stimulation with brandy that it was kept alive. During the night and the next morning it passed frequent thin diarrhœal discharges; and, the exhaustion increasing in spite of the stimulants and other measures employed, death ensued in about twenty-four hours. An autopsy was made ten hours after death with the assistance of my friend, Dr. E. L. Keyes. The body was pale and emaciated, showing to a marked degree the debilitating effects of the inherited cachexia. The thymus gland and portions of the liver and lungs were removed for microscopic examination; the other thoracic and abdominal organs were healthy, and the brain was not examined.

The specimens removed were subjected to several careful microscopic examinations, with the following result: Each section of the liver, which it may be observed was enlarged and speckled with grayish masses about the size of small peas, showed evidences of interstitial hepatitis. These grayish masses consisted of fibro-plastic elements intermingled with the parenchymatous structure; the capillary net-work being obliterated in some cases, and in others merely compressed and condensed. The hepatic tissue was generally indurated, and creaked slightly when cut, the gray masses exuding a serous liquid, but no blood. The entire condition of the liver accorded closely with the description first given of the lesion by M. Gubler.¹ The thymus gland was thought to be rather larger

¹ *Gazette des Hôpitaux*, Jan'r, 1848, and *Gaz. Méd. de Paris*, 1832, pp. 262 et seq.

and softer than usual, but showed no evidences of suppuration, and contained none of the yellowish white grumous liquid considered by Dubois¹ as a certain indication of congenital syphilis. In the lungs no specific nodules or indurations could be discovered; here and there the parenchyma was softened in minute spots, but none of these points showed any pus. The intercellular walls were thickened and indurated, the hypertrophy being apparently due to a soft fibrinous deposit on the outside of the cellular wall. In one portion of the right lung the tissue was almost hepatized by the large amount of this deposit, and was so heavy as scarcely to float in water. No atelectasis existed in either lung, and no gummy tumors, properly so called, were found in any organ.

Remarks. These *post mortem* results, added to the chain of events previously described, seemed to leave no room for doubt that the case was one of syphilitic pemphigus; and to add another to the proofs already on record that infantile pemphigus is frequently an evidence of inherited syphilis. This point has been often denied, and is so to the present day; Diday,² among other syphilographers of note, holding its non-specific nature. Oslander in the last century, and more recently Krauss³ and Gilibert,⁴ were of the same opinion; and in 1851 a notable debate occurred in the Academy of Medicine at Paris, in which M. Cazeaux supported a similar view against Paul Dubois. A full account of this discussion is given in the work of Diday who, in common with Trousseau, Bazin, and a few others of prominence, refused to admit any causal connection between the eruption and the syphilitic vice. The facts, well established in this, and the subsequent discussions to which it gave rise, that the parents of children born with pemphigus are generally syphilitic, that this lesion in the child is usually associated with the recognized visceral lesions of syphilis, and finally that the only cases of this affection that

¹ Gaz. Méd. de Paris, 1850, pp. 392, et seq.

² Traité de la Syphilis des Nouveau-Nés, p. 120.

³ De Pemphigo Neonatorum, Bonn, 1836.

⁴ Monographie du Pemphigus.

recovered, were cured by anti-syphilitic treatment, will probably seem conclusive to a candid inquirer.

Rupia and ecthyma are the only eruptions with which pemphigus is likely to be confounded; from the former it is distinguished by the distention and elevation of the bullæ, which are larger and better defined, and usually occur in groups, while the crusts which follow the bullæ are not so thick or tough. In ecthyma the eruption is pustular from the first. From non-specific pemphigus it differs in the superficial ulceration of the skin under the bullæ, which never occurs in simple pemphigus. Dubois and Lancereaux¹ also assert that the specific variety is apt to be confined to the palmar and plantar surfaces, but this has been shown to be unreliable.

As a manifestation of syphilis it is almost invariably congenital, although Bassereau² records two exceptional cases of the eruption during the evolution of acquired syphilis.

The *prognosis* in infants is extremely grave, and in proportion to the degree of the syphilitic cachexia. After a few days of feeble life, a tendency to vomiting and diarrhœa sets in, and death ensues from apparent exhaustion, but in reality because the viscera are so saturated with syphilitic deposits as to be incapable of performing their functions.

¹ Traité de la Syphilis, p. 546.

² Affections Syphilitiques de la Peau, p. 402.

NOTES AND COMMENTS ON DERMATOLOGY.

BY HENRY S. PURDON, M.D.,

Physician to the Belfast Hospital for Diseases of the Skin, and to the General Hospital.

THE following remarks briefly note a few of the principal new methods of treatment, &c., published during the past year in Great Britain and Ireland:

CARBUNCLE.—A valuable paper on carbuncle, from the pen of Dr. Eade, of Norwich, appeared in the *Lancet* for December 11th, 1869. It contains the case of a patient aged 74 years, stout and robust for his age, but subject to chronic mania. This individual was attacked by carbuncular inflammation on the neck, which was rapidly cured by making a free crucial incision, poulticing, and subsequently applying, on lint inserted into the incisions, a liniment consisting of one part of carbolic acid to five of oil. The disease seemed inclined to spread. In order to prevent it doing so, a superficial slough was made with the acid nitrate of mercury, two inches in diameter. In addition to the previous treatment, supporting diet, &c., were also ordered. Dr. Eade remarks that he was led to take this method of treatment owing to the observations of Mr. Startin, the senior surgeon to the Skin Hospital, Blackfriars, London (*British Medical Journal*, November, 1866), who regards “these maladies (boils and carbuncles) as having frequently a parasitic origin. . . .” “I should mention,” he says, “that this opinion is rather borne out by the success and efficiency of the practice in the cure of this ailment, than by microscopic verification, though in an example or two, amongst many failures, this test has demonstrated cryptogamic vegetation resembling that found in sycosis.”

We know, from the experiments of Professor Tyndall, at the Royal Institution, and from the researches of M. Pasteur, Mr. Lister and others, that the air we breathe is charged, especially

in cities, with organic matter, and that germs of low growth thus gain entrance into wounds, causing suppuration, &c. Nor is it at all improbable that these organic particles, spores of fungi, &c., floating in the air, after alighting on a "suitable soil," give rise to the class of diseases popularly called "ringworms," the most common form of which is *tinea circinata*, the most matured, *favus*, and the least expressed, *alopecia areata*; indeed, the latest view is, that we have only *one* fungus which, in its different stages of development and growth, gives rise to various cutaneous lesions known by the above names. This dogma has the support of Dr. Tilbury Fox.

ECZEMA is a disease that of late years has attracted much attention. In acute eczema the follicles, papillary layer, and superficial layer of the corium are swollen; in chronic cases the skin is thickened, owing to sub-cutaneous infiltration, the natural lines and furrows being deepened and the papillæ enlarged. Mr. Erasmus Wilson considers that debility, either local or constitutional, is the cause of eczema. The latter he divides into four varieties, viz., *nutritive*, *assimilative*, *nervous*, and *hereditary*. Of eczema he makes six groups, as E.—erythematodes, E.—papulatum, E.—vesiculosum, E.—ichorosum, E.—pustulosum, and E.—squamosum. Mr. Milton considers that the different appearances of eczema are due to the stage of the disease, health, and constitution of the patient. He likewise believes that the "essence of eczema, the test of its nature, to be a weeping surface, and I consider that a true weeping surface is never produced from an eruption of vesicles or pustules. . . . Pustules may, however, complicate it; they do not necessarily form any part of the process." Dr. Tilbury Fox looks on eczema as a catarrhal inflammation of the skin, and holds to Willan's view of the primary lesion being a vesicle. Dr. McCall Anderson, the exponent of the Vienna school in Great Britain, groups together erythema, lichen, prurigo, impetigo, &c. If we carefully study the views of these distinguished British dermatologists, although they may seem to differ on many points, still, on several they agree, as, for instance, it is generally admitted that debility is the chief cause of eczema, and as regards treatment,

to soothe and allay irritation when the disease is acute. Stimulate and remove infiltration in chronic cases.

MORPHŒA ALBA ATROPHICA.—The writer has lately met with a case of this rare complaint occurring in the person of a female, aged 56. The patient has always been in good health. Twenty years ago a small boil appeared on her right cheek, which, after being lanced, healed without any trouble. A few years since she remarked the skin on that part becoming whitened. At the present time a cicatricial looking tissue is exhibited about three inches in diameter, very smooth, glazed, and white-colored, the margin of the patch having a violet tinge. The affected skin is greatly thinned and accompanied by *loss of substance*, the hair follicles and natural openings are obliterated. The appearance presented by this patient resembles a case described by Mr. E. Wilson (*Journal of Cutaneous Medicine*, Vol. II., page 171) of a girl who attributed the disease to the bite of a gnat.

DERMATOPHYTIC DISEASES.—I have shown in the last number of the *Journal of Cutaneous Medicine*, in a paper on the subject, that the presence of damp favors the growth and development of favus, and have quoted tables of rain-fall in different towns, together with the prevalence of favus, compiled from hospital returns, towards proving my assertion. It is a fact worthy of notice that the vegetable moulds assume various forms, according to the localities and circumstances in which they are placed. Dr. Tilbury Fox thinks, that to account for this change, “we must look for an explanation of the differences between the varieties of tinea, not so much in difference of fungus as of soil and seat upon which they grow.” Any one engaged in a large cutaneous practice must have observed the occasional occurrence together, of tinea circinata, and favus. I have met with four such cases. One of these was a boy aged 7 years, who exhibited tinea circinata in its declining stage, on the neck and chin. In the centre of one of the rings were several well-marked favus cups on the chin; however, the disease had assumed a tubercular character, and if this part had been covered with hair, I should have probably called it sycosis. No doubt the ordinary forms of “ringworm,” viz., tinea

circinata, tinea tonsurans and sycosis, are due to the same parasite,—the trichophyton tonsurans. If we take a step further and acknowledge the achorion to be a more matured form of the trichophyton growing on a more favorable soil, we shall not be far from the truth. The researches of Tulasne and De Barry, quoted by Dr. T. Fox, have “contributed to the establishment of the doctrine of polymorphism, which implies that one fungus may pass through a cycle of development, and in its different stages giving rise to many different forms originally regarded as distinct species.”¹

ICHTHYOSIS.—Dr. C. Hilton Fagge has contributed a paper on this disease to *Guy's Hospital Reports*. He thinks that there “exists grave doubts as to there being any form of ichthyosis, or any disease to which the name of ichthyosis would naturally be applied at the present day, in the production of which an accumulation of sebaceous matter plays any but an insignificant part.” In one case recorded, our author found the crusts to consist of conical masses, each of which was made up of smaller portions, superimposed the one on the other, and evidently formed on the surface of the same papillæ. Dr. Fagge found that the cellular linings of the hair sacs were greatly increased in thickness, and he proceeds to say that “by some writers the absence of redness and inflammation is made a cardinal point in diagnosis of ichthyosis. My own observations, on the contrary, lead me to believe that parts of the skin which are the seat of ichthyosis, at any rate in its less severe forms, are particularly liable to become inflamed. This inflammation shows itself in various degrees. The commonest grade of it, is when a part ordinarily affected with simple Xeroderma becomes red, and its thickened cuticle begins to peel off in large lamellæ. Infants who are the subjects of ichthyosis are frequently brought to one in this condition. Under the use of *vinum antimoniale* internally and emollient applications locally, amongst which I have found the *glycerinum amyli* very valuable, the redness and scaliness are after a time removed.” Infants distinguished by the odd title

¹ See Dr. Tilbury Fox's Manual.

of "harlequin-foetus" are sometimes met with in whom the skin is cracked into symmetrical fissures, evidently due to imperfect nutrition.

SCARLATINA has been very prevalent in the United Kingdom during the last twelve months. The cases observed by the writer were in many instances accompanied by a good deal of infiltration of subcutaneous tissue in the region of the neck, frequently ending in abscess. Regarding treatment, much benefit was derived from the old remedy, chlorate of potash, given with diluted hydrochloric acid, the latter being extremely serviceable when acute catarrh of the stomach complicates the disease, as it dissolves the tenacious alkaline mucus, coating the walls of that organ, thus allowing nourishment to be absorbed. This important fact was first pointed out by Dr. Sisson.

With the idea of supplying oxygen to the blood, the peroxide of hydrogen in drachm doses, for a lad say of sixteen years, together with ten drops of tincture of steel was prescribed in serious cases.

TINEA.—No class of diseases are more annoying than those designated by the name of "ringworms." In *tinea circinata* and *tonsurans* one or two applications of a solution of chromic acid ($\frac{3}{4}$ i to the $\frac{3}{4}$ i of water) has in the writer's hands proved very efficacious in curing the disease. Sometimes liquor potassæ painted over the affected part answers very well, or a solution of carbolic acid, which remedy checks the development of spores, and also prevents them from germinating.

PHTHEIRIASIS.—A good cleanly remedy for pediculi wherever situated is a lotion containing the yellow oil of sandal wood, suspended by means of glycerine and rectified spirit. This essential oil has a powerful odor, which destroys the insects.

SCROFULODERMA.—The acetate of soda, eight grains to the ounce, has been recommended by Dr. McCall Anderson, of Glasgow, as an application in strumous affections, but in the writer's hands has been found to be inferior to the iodide of lead ointment. A popular country remedy is an alcoholic solution of walnut leaves. The injection of tincture of iodine. 4

to 8 drops, into glandular enlargements has been lately recommended, and has been tried in several cases at the Belfast Hospital for diseases of the skin. An ordinary hypodermic injection syringe answers very well. Care must be taken to avoid any of the superficial veins. After a few injections the glandular swellings become hardened and rapidly absorbed. Sometimes symptoms of iodism are exhibited, when the remedy must be discontinued for a short time.

PRURIGO.—The best local remedy for this troublesome complaint is in the hypodermic injection of morphia.

ULCER.—Dr. Fayrer, Professor of Surgery in the Medical College of Bengal, has published (*Edinburgh Medical Journal*, Dec., 1869) some cases of ulcers, &c., treated with the local application of petroleum, and he thinks that it is a stimulating and detergent application slightly irritating, and as useful as carbolic acid. It is also a good remedy in scabies, being usually employed in the form of soap.

ULCERATION OF SEPTUM NASI.—Pereira recommended an ointment containing one drachm of the nitrate of bismuth to the ounce of lard as a local application in this disease. A short time since an interesting case of ulceration of septum nasi was under observation, and which was cured by the use of this ointment, after nitrate of silver, tannin and glycerine, &c., failed. Lotions containing bismuth are of advantage in skin diseases when much inflamed.

ON THE TREATMENT OF EPIDIDYMITIS BY SULPHURIC ETHER.

BY A. ASSADORIAN, M.D.,

Resident Surgeon to Charity Hospital, New York.

ACUTE EPIDIDYMITIS, either gonorrhœal or traumatic, when treated by local depletion, cold, or poultices, requires an average of two weeks' confinement in the recumbent position. To this method I was quite partial, but it occurred to me that the inflammation might be cut short by the application of sulphuric ether, and my experiment resulted successfully, for in several cases in which it was tried, the enlarged gland and cord were reduced to their normal size, and the pain ceased in two or three days. Upon first application the patients complained of a burning sensation, but this entirely ceased upon the second or third.

My usual plan is to elevate the bed-clothes by a basket-work or hoop, so as to favor free evaporation. The testicles being elevated by oakum, a piece of lint is wetted with the ether and laid over the inflamed testicle and cord, and kept *constantly* wet. It is necessary to direct the patient to make the application regularly, as the cure is retarded if the application is not continuous. The usual quantity of ether required is about three bottles of Squibb's ether fortior. The following case will show the rapidity of diminution of the inflamed testis :

One of the attending surgeons having been shown a case of epididymitis in the fifth week of gonorrhœa, signified his intention of delivering a clinical lecture upon that subject upon the day following, when, having described the hard, swollen and painful condition of the epididymitis to the class, he was astonished, upon feeling the testis, that these classical symptoms were wanting ; the man had been treated by evaporating applications of ether.

HISTOLOGICAL CONTRIBUTION.

BY HENRY G. PIFFARD, M.D.,

Surgeon to the New York Dispensary for Diseases of the Skin.

AN accurate knowledge of the histological changes taking place in the different cutaneous lesions is the greatest present desideratum in dermatology ; but the practical obstacles in the way of obtaining material have, heretofore, been so great, that comparatively little has been done to increase our information.

The methods usually employed are, first, to remove from the cadaver a portion of morbid integument, and immerse it in a hardening solution of chromic acid, bichromate of potash, etc. After hardening, a thin section is made with a razor or Valentine's knife, or the specimen may be imbedded in wax or paraffine, previous to section. The difficulty here is, to obtain a sufficient supply of material—corpses with cutaneous lesions being a rarity.

Secondly, we may remove, with the scalpel, a portion of skin from the living subject, then immerse it for two or three weeks in the hardening solution, or proceed as before ; or, instead of hardening, employ the process of *gum imbedding*, or make sections of the tissue in a comparatively recent state ; or, what is still better, if we can accomplish it, make an immediate section of the fresh tissue. The thin section being obtained, we can then examine it microscopically ; but if we desire to preserve it for future observation, it will be necessary to submit it to additional processes. It may be mounted immediately in cells with glycerine, or some other preservative fluid, or what is less troublesome, glycerine jelly (Beale's formula). If, however, we desire to mount in Canada balsam or damar, we must immerse the section in strong alcohol afterwards, or turpentine before the application of the balsam. The alcohol removes all water from the tissue, as the turpentine prepares it for a thor-

ough penetration of the balsam. These various processes differ in their comparative convenience of application, but a point of far more importance is the relative condition in which the section remains after being submitted to them. Have we, in a fairly-mounted balsam preparation, a reliable representation of the histological changes which have taken place in the specimen we are submitting to examination? This can only be ascertained by a comparison of results. A patient with extensive psoriasis having presented himself, we removed from his left side, with the scalpel, a portion of morbid integument sufficient for our purpose. This was divided, a one-half placed in Müller's solution; the other was immediately imbedded in a mixture of white wax and olive oil. When the wax had hardened, section with the razor was attempted, but unsuccessfully, the tissue being too soft, yielded before the blade, and could not be cut of sufficient thinness. We then covered the exposed surface with a layer of strong collodion. In a few moments the ether had evaporated, and the outer surface of the specimen was firmly held by the cotton. The razor being then introduced under the thin stratum of cotton, we were enabled to obtain very satisfactory sections. After section, the dried cotton is readily detached from the tissue. Of these sections a portion were stained with carmine, and immediately mounted in glycerine jelly, while others were placed in alcohol or turpentine, or mounted in balsam. The other portion, which had been placed in Müller's solution, was removed after two weeks, and sections made from it in the usual way were mounted in balsam. The different specimens were then submitted to a comparative microscopic examination. Without entering into a minute statement of the changes observed in psoriasis, so well described by others, we will briefly state that in all the specimens we found, the papillæ increased in length and breadth, and the rete malpighii in thickness, but we were much struck by the different appearances presented by the papillæ in the sections treated in different ways. In the fresh jelly mountings they were of an average length of .0093in. (about .23mm.), and breadth of .0047in. (.11mm.), while in balsam mountings they were only .006in. (.15mm.) in length, and .002in.

(.05mm.) in breadth. It was clear from this that the papillæ, and probably other portions of the tissue, were not only greatly shrunk, but their *relative* proportions distorted by immersion in alcohol, etc. This observation, and others of a similar nature, led me to doubt the value of the result obtained from the examination of hardened tissues, and to seek to devise means by which specimens from the living subject might be studied in a recent condition. The difficulties in the way were the unwillingness on the part of patients to part with portions of their integuments of requisite size, and the difficulty of obtaining, even with the collodion process, satisfactory sections. These, however, may be overcome by the use of the "Cutisector," which it is the object of this communication to bring to the notice of those interested in cutaneous pathology.



THE CUTISECTOR.

The instrument represented in the cut, about one-half its natural size, consists of two parallel blades, which may be approximated by means of screws. The knife being held as a pen, a perpendicular incision may be made through the whole thickness of the skin, and the knife withdrawn, leaving attached a thin slice of tissue which can be easily removed with a pair of fine forceps, and placed under the microscope. The pain of the operation is of course not great, and may be entirely obviated by the local application of ether spray. The wound heals by first intention if its edges are approximated, and leaves no scar. With this instrument we have obtained some very beautiful sections. The advantages which we think it possesses are, that we are enabled to obtain satisfactory sections of *fresh* tissue without serious inconvenience to the patient, and to study the changes taking place in them under the most favorable conditions. As an aid to positive diagnosis, its employment will become more extended as our knowledge of cutaneous histology advances.

Reviews.

THE DOCTRINES OF UNICISM AND DUALISM OF THE SYPHILITIC CONTAGION.¹

IN the following Review we desire to present the conflict of opinions entertained by syphilographers of the present day, who assail and defend their respective doctrines with zeal and asperity.

The moot point is, whether the soft chancre and constitutional syphilis originate in one and the same poison, or whether the respective affections are the products of two separate contagions.

The contest is of recent date. The originators and earliest followers of the theory, which is now called dualistic, were Bassereau and Clerc, who, about 1852, enunciated the doctrine of the absolute non-identity of the two affections, thus liberating themselves from the authority of Ricord, which had for so many years held sway.

However, they did not exactly originate a new doctrine, but, in fact, it was the very first idea held relating to the disease; for at the time of the first appearance of syphilis towards the end of the 15th century, no one in any manner even regarded this entirely new disease as at all identical with the long known "caroli, or caries pudendorum, or *ἐσχάρᾱ*, or *αἰτίρας*, robigo, or cancer," and whatever other synonyms had been used for the contagious ulcers of the genitals, and the surrounding parts, in ancient and mediæval times. Constitutional syphilis or, as they generally termed it, "morbus gallicus," was spoken of as "morbus novus et inauditus," an entirely new and unheard of disease. Still more, in regarding the primary lesion, the hard ulcer, or whatever it might have been, to be an accidental complication, they failed to establish any connec-

¹ For the details of many of the facts, historical views, and experiments given in this Review, see the valuable works of Geigel. *Geschichte, Pathologie und Therapie der Syphilis*. Wurzburg, 1867. Auspitz, *Die Lehren vom syphilitischen Contagium*. Wien, 1860. For other quotations, see text.

tion between this ulcer and the new disease, which presented such markedly different symptoms. Thus, it happened, that in the earliest times coitus was not considered to be the fons et origo of the propagation of syphilis ; its source was sought in different noxious influences, and its seat was located principally in the liver, where a general destruction of the cardinal juices was supposed to have taken place. When a short time afterwards the venereal origin of the trouble was suggested, it was disputed by many, and one of the contemporary physicians either with *naïveté* or malice stated, that the fact of its prevalence among priests and in monasteries was an argument against it. It was not long, however, before this matter was settled, for very soon it was found out that the disease appeared more particularly after suspicious connections. According to the views of the now obsolete humoral pathology, it was then considered to arise from decayed menstrual blood ; later still it was observed that in the majority of cases Caroli on the genitals preceded the evolution of the disease, which Caroli could scarcely be differentiated from the long known ones, and therefore they spoke of caries pudendorum after cohabitation with a prostitute, and of caries gallica, without knowing any other difference, except that morbus gallicus followed in one case, while in others it did not. A little later still it was entirely forgotten, that such ulcers had been known before the outbreak of the morbus gallicus, and thus it came that as early as the middle of the 16th century, chancre and syphilis were entirely identical phenomena. Fallopius who knew of the existence of the ulcers before the appearance of morbus gallicus, did not think they had been real chancres, but merely simple non-contagious ulcers. This view which prevailed for a long time, was revived two centuries later by Astruc, and finally refuted by Hensler, Gruner, Sprengel, and others.

Chancre and syphilis thus came to be regarded as identical, and this state of knowledge remained undisputed until toward the end of the 18th century. At that time several eminent physicians, especially Bell, Swediaur, and Hunter, again laid stress upon the fact, that not all ulcers of the genitals, but only a small part of them were followed by constitutional syphilis. Hunter even went as far as to deny the chancreous nature of most of them, which according to the prevailing views of his times was a denial of their syphilitic nature. He emphatically stated that only a certain variety of the ulcers, namely, the indurated ones, were real chancres, from which fact they were afterwards called Hunterian chancres. A little later

Carmichael, working out this view, differentiated five pseudo-chaneres, which served only to increase the confusion.

I will only mention that in the second and third decennium of the present century the disciples of Broussais, the so-called physiological school, and among them particularly Caron, Richond de Brus, Devergie, Desruelles, and others, denied entirely the existence of a syphilitic virus, and regarded all the manifestations of syphilis as simple inflammations.

The immediate follower of this school was Ricord, who totally refuted their doctrines; and as from him dates a new era in the views upon venereal diseases, it is necessary to detail his ideas in extenso. Elaborating upon the experiments introduced into syphilidology by Bell and Hunter, he perfected them by freeing them from many inaccuracies and oversights, which had so often led his predecessors to error. With the aid of these experiments, controverting the opinions of the Broussaisists, he demonstrated the existence of a syphilitic virus, which means chancre virus. Further he differentiated gonorrhœa from chancre, especially by demonstrating the *chancre larvé*, the urethral chancre. The fact that this lesion had not been recognized previous to that time had led to great confusion, as observers, regarding all urethral discharges as gonorrhœa, and inoculating such matter with good result—argued that gonorrhœal matter was inoculable. Ricord finally demonstrated, at least to the satisfaction of his contemporaries, the unity of the syphilitic virus with certain modifications which will be presently considered. Setting aside as too prolix the details of the investigations upon which he founded his doctrines, I will briefly give the results which he arrived at, and which for nearly twenty years formed the impregnable and infallible gospel of the syphilidological world.

The full details of the experiments and investigations which Ricord instituted from 1831 to 1837, principally at the “Hôpital des Vénériens,” may be read in his celebrated book, “*Traité Pratique des Maladies Vénériennes*,” Paris, 1838. The contents of this book, as setting forth the original doctrines held by Ricord and his school, may be concisely stated in the following aphorisms :

1. A syphilitic virus does exist.
2. There is but one syphilitic virus.
3. The only constant pathognomonic symptom of the chancre is not the seat, the color, the hardness, etc., but solely the secretion of pus with infecting qualities.
4. The lesion produced is a pustule, if the matter lodges beneath the epidermis; an ulcer, if placed upon an excoriated

surface ; an abscess, if introduced into subcutaneous tissue—the virus being always one and the same.

5. The chancre poison acts immediately, having no period of incubation, but merely one of evolution.

6. At its inception, the chancre is a local lesion, capable of propagating only a chancre.

7. The constitutional secondary symptoms must of a necessity have been preceded by a chancre, though a chancre need not be followed by those symptoms. As a rule, they only follow if the chancre indurates, the induration usually not commencing before the fifth day.

8. If the chancre is totally destroyed before the fifth day, general infection does not take place.

9. The only vehicle of the virus is the pus of the chancre or its concomitant bubo. The secondary and tertiary symptoms and their products are not transmissible, not contagious.

10. Per contra, the chancre is always contagious ; there is no immunity against its action.

11. An indurated chancre or constitutional syphilis is only communicable once in a person's life-time.

12. Whether a chancre will or will not indurate, depends upon the predisposition of the individual or of the affected part of the body. On the head the chancre invariably indurates.

It is easily explicable that these teachings of Ricord were greeted and accepted by his contemporaries with great applause ; for adverse to the mere philosophical views of the Broussaisists, and adverse to the anti-Broussaisistic confusion, which was also produced by mere speculation, we find in the writings of Ricord clear logic, based upon facts, and resulting from close observation, all this set forth in a racy and fascinating style. Even in our day, when quite different views are entertained upon the subject, some of his original opinions are still uncontroverted. In fact, in the following years his opinion of the non-contagiousness of the secondary lesions and their products was the only one upon which there was dissent. To settle this question, numerous experiments were instituted, which will hereafter be carefully considered. But in his second grand work, in the *Lettres sur la Syphilis*, which were published in the *Union Medicale*, 1851, he still adhered to the non-transmissibility of constitutional manifestations. Regarding many other points, we notice in this second work a marked change of views, which shows a tendency to separate the two forms of the primary affection. This change of views was the natural consequence of a more careful study of the indurated

ulcer, which previously, by him and others, had been neglected in the experiments of inoculation. In his nineteenth letter he reprints in italics the statement of Diday and Puche, to wit : that constitutional syphilis is absolutely inseparable from the indurated ulcer ; and by this fact he gives to this lesion such a distinct characterization above the simple chancre, that it was only a small step to the affirmation that they were entirely different accidents ; and it appears almost incomprehensible, why so bold a man as he has not taken that step himself. In the same letter he alludes to the analogy between chancre and syphilis and vaccine and variola, and goes as far as to call the ordinary chancre, like Carmichael, a pseudo-pustule.

Again one must admire the acuteness of observation, with which he connects and correctly describes the various conditions as parchment—induration, infiltration after cauterization, date of appearance, *et cet.*, without any satisfactory explanation, even from false premises.

It is necessary to mention Ricord's views upon buboes, which in the two works above quoted are in the main identical. He describes two varieties of venereal buboes : 1st, those which are the immediate result of absorption—*bubon d'absorption*—and 2d, those which are the consequence of constitutional infection. The first class includes two species, the one follows the soft chancre and its varieties and invariably suppurates ; the other is concomitant with the hard ulcer in the form described by Hunter, as indolent rosary-like adenitis, and seldom suppurates. The pus of the first variety is inoculable, that of the second is not. He totally discards *bubon d'emblée*. One very characteristic evidence of his change of views, however, we find also in this matter of buboes ; for in the "*Traité des Maladies Vénériennes*," he says : "A bubo which *does not* furnish inoculable pus is never followed by constitutional syphilis, for it is a simple adenitis, which may arise from any cause," whereas in the "*Letters*," he says : "A bubo which *does* furnish inoculable pus will never be followed by constitutional syphilis, for this pus originates in a non-indurated chancre." This direct contradiction was simply the result of the differentiation of the two forms of primitive ulcer.

Before proceeding to the history of the entire separation of these two forms, we will first review the experiments instituted to determine the contagiousness of the secondary manifestations of syphilis. Wallace, of Dublin, was the first who tried the experiments of inoculating constitutional syphilis upon healthy persons. While searching for his lectures in the *Lancet*, in which these experiments are given, we noticed casually

a previous communication of Wallace, from which we inferred, that even at the time of his experiments he had been for a long time from clinical observation aware of the transmissibility. In this communication he describes the case of a girl seventeen years of age, who had been infected by a child, who had hereditary syphilis, and of which she was the dry nurse. At the end of the article he says: "Numberless are the analogous cases which I have seen, and in all these cases it was the matter of secondary sores which propagated the disease. Mr. Hunter and his followers, who deny that secondary syphilitic sores are infectious or contagious, are quite mistaken."

In proof of this fact Wallace made the following experiments, which are published in the *Lancet*, Vol. 31st and 32d, 15th to 19th clinical lecture on diseases of the skin and venereal diseases. The experiments were nine in number, all of them inoculations upon healthy persons, but it is to be regretted that he obtained his matter from not always reliable sources. In the first three the pus was taken from venereal ulcers, whether primary or secondary is not absolutely certain, but auto-inoculation had failed, and Wallace describes them as undoubtedly indurated. His method was to smear the pus upon a spot excoriated by friction, which resulted as follows: After four weeks inoculation there appeared at the inoculation point, which had completely healed, a livid prominence of the integument, upon which later on an ulcer developed; well pronounced induration of base occurred only in one case, but in all three indolent engorgement of the neighboring lymphatic chain took place, and general symptoms followed. In two other inoculations the contents of psudracic syphilitic pustules, the specific nature of which was indubitable, were used, and introduced under the skin by a lancet, with the following result: The period of inoculation was again twenty-eight and thirty-one days, at the end of which at the place of inoculation, which had also healed, red papules appeared, which soon ulcerated, did not present a hard base, supplicated freely and had indolent ganglia in vicinity. Two months after the inoculation constitutional symptoms appeared. The four following experiments are not suitable to our purpose, because though in one case general manifestations followed, judging from Wallace's description, they were made with the pus of simple chancres.

It is certainly remarkable how the observations of Wallace, who was so painstaking and reliable an observer, and whose results bear the impress of so much responsibility, were utterly ignored by his contemporaries. But twenty years later, when

attention was paid to similar investigations, they were revived. The principal cause of this oversight was the blind adoration of Ricord, who with taunting sarcasms and bombastic phrases overrid his adversaries. Ricord's objections against Wallace especially, which appeared much later, at the time of the "Lettres sur la Syphilis," are inappropriate to our review, for they were absolutely of an unscientific nature, and, directed against a man like Wallace, they were even indelicate and improper.

The experiment next to be considered was instituted by Vidal in 1849 in the Hôpital du Midi; and became particularly famous from the fact, that in the French Academy a lengthy and acrimonious discussion originated from it, which only ceased in 1859 by the report of the committee, of which Gibert was chairman, and which we will consider further on. The experiment itself, viewed from the present standpoint of syphilography, is clear and satisfactory, but at that time it proved much less than Wallace's experiments. Its weak point was, that the matter from the ulcers which had been used, had given positive results in auto-inoculation, and Ricord, therefore, was able to say with justice they had been simple chancres, more especially as immediately after the inoculation pustules had formed, which in a fortnight had cicatrized; but five weeks afterwards new pustules appeared from which general symptoms originated. It was exceedingly negligent to use auto-inoculable pus in this experiment, although it was taken from a pustule on the left side of the breast, and although all the other symptoms as described by Vidal in the *Gazette des Hôpitaux*, speak strongly in favor of the syphilitic nature of these pustules. The consequence was, the experiment lost all its worth under the influence of Ricord's objections, and made the heroic young Pharmacien, who had proffered his body for the experiment, a useless martyr of science.

We now proceed to the experiments of Waller in Prague, which were of much more value, and upon which Ricord's polemics and cutting witticisms fell powerless. They were published in the 29th volume of the *Prager Vierteljahrsschrift* in 1851, and at that time created a deservedly immense notoriety. Waller, as did Wallace, instituted his experiments to prove facts, which he had previously observed clinically. Some of these observations which form the first part of his article are as follows: 1st. A healthy child two years of age was suddenly attacked by condylomata lata on the labia majora, perinæum and anus; the parents had never been syphilitic, and eight other older children were healthy. On close research it was found that the child's nurse, who had been with

them three months had condylomata at the angles of the mouth, the inner surface of the lips, upon the labia pudenda, etc. 2d. Three mothers with condylomata lata of the genitals and exudations on the mucous membranes of the lips, angles of the mouth, and the tongue, brought each one a child of from two to three years into the hospital, which children all three presented similar affections; two of them had macular syphilide over the whole body; the syphilis was not inherited, and there was no trace of primitive affection. 3d. A woman thirty years of age, whose husband was healthy, had at the base of each nipple a condyloma latum, ulcers in the throat, and macular and papular syphilide; she had infected herself from a foundling she had nursed. 4th. A man became syphilitic in Dec., 1848; he had angina and syphilitic iritis, and seemed to be entirely cured at the end of the following June. Towards the close of the year 1849 he married a perfectly healthy girl; in the honeymoon the coitus was guardedly indulged in, by reason of the pain which it produced in the woman, who had previously never had any intercourse with men. At the end of December both man and wife had a slight flow of blood during the act, and in January, 1850, the woman noticed a macular and squamous syphilide over the whole body, and, a little later, condylomata appeared on the pudenda. The man neither then nor thereafter showed any evidence of the disease.

Influenced by these observations, Wallace made two inoculations, one with the pus of condylomata lata, and another with the blood of a syphilitic individual upon healthy persons. In the first case, the incisions were made with a clean scarificator, and matter from mucous patches applied. Four days afterwards they had all healed. Twenty-five days after the inoculation fourteen tubercles were visible upon the cicatrized points of incision, the greater number of them were confluent and formed a desquamating patch of the size of a silver dollar, slightly elevated and nodulated. Twenty-seven days after the appearance of the tubercles, and fifty-two days after the inoculation, a macular syphilide appeared.

In the second case the inoculation was done by scarifications made with a perfectly new scalpel, and blood of a syphilitic girl was applied with charpie. The scarifications healed readily. Thirty-four days afterwards, two distinct tubercles of the size of a pea, of a pale red, dry and without pain or itching, appeared at the place of inoculation. They shortly coalesced and were surrounded by a dark, coppery-red areola; they indurated and ulcerated, and thirty-two days later, that

is sixty-five, days after inoculation a macular syphilide appeared.

Ricord's objections to Waller's observations and experiments, not to speak of the personality of the attack, are insufficient and utterly irrelevant. Speaking of the observations, he doubted the correctness of the diagnosis of the condyloma, and of the experiments he supposed that pus of a chancre had accidentally contaminated the inoculated points. Taken as a whole, they were similar objections to those of which Cazenave, on a previous occasion had said, they were not worthy of comment.

The remaining recorded instances of experimental transmission of secondary syphilis, which have always been undertaken with the idea of the unity of the syphilitic virus, are very similar to those of Wallace and Waller, both in their method of performance and their results. They are :

1st. The experiment of the German physician, Lindmann, that heroic martyr, who transmitted to himself the virus from secondary ulcers of tonsils. He presented himself to the Academy, suffering besides his constitutional disease, from innumerable chancres over the whole body, as he had essayed to cure himself by syphilization. Subsequently the experiments of Rinecker,¹ who successfully inoculated from syphilitic acne and from suppurating tubercles of the arm upon two young physicians, and a boy afflicted with chorea.

Then the experiments of the so-called anonymous surgeon of the Palatinate, who successfully inoculated with pus from mucous patches and from rhagades behind the ear, and with blood of syphilitic persons.

Still later, the experiments of Bärensprung, of Berlin, who only became convinced by the results of his own inoculations.

And finally, omitting some of less importance, those reported to the French Academy by Gibert in the above quoted report of the committee, which conclusively settled the question, although the sentiment of the report was markedly lukewarm.

In the meantime Ricord had also forsaken his former opinions and had expressed his ideas to that effect in the *Leçons sur le chancre*, edited by Fournier in 1857 ; the book begins with the words : "*Messieurs ! un poëte a écrit : l'homme absurde est celui qui ne change jamais.*"

But it was now evident how extensive and deeply rooted had been Ricord's influence, for they even then spoke of a new school of Ricord, although it had been necessary that its master

¹ Würzburger Verhandlungen, Vol I. and III.

should be coerced to adopt its views. But we accept the denomination as correct from another point of view, for indeed the doctrines which we shall now proceed to consider, and which form the main object of this review, emanated from disciples of Ricord.

Bassereau, a disciple of Ricord, in his work, "*Traité des affections de la peau symptomatiques de la syphilis*," first propounded the view of the entire difference between the poisons, which produce chancre and syphilis.

He had arrived at this conclusion by very minute and painstaking observations, made in a large number of confrontations of syphilitic persons with those by whom they had been infected. Of thirty-four individuals who had been exposed to the contagion of a hard chancre, thirty-one had become syphilitic. In the three others, an early mercurial treatment was said to have prevented the evolution of general symptoms. Reasoning upon these cases and numerous other confrontations of cases of soft chancre, he drew the conclusion that: "the ulcer which precedes constitutional syphilis always gives rise to an ulcer, which is followed by similar symptoms; on the contrary, soft chancres and ulcers produced by them remain local, and only by absorption cause suppuration in the neighboring lymphatic glands." He therefore called them respectively: "*Chancre précurseur de la vérole*," and "*chancre a bubon suppuré*." In further demonstration of these views, Bassereau adduced historical proofs, which we will consider in their proper places.

Two years later Clerc published a pamphlet: *Du Chancroïde syphilitique*, Paris, 1854, in which he confirmed Bassereau's opinions, and rendered them more precise. He propounded three propositions:

1. There are two totally distinct varieties of chancre; the soft or non-infecting, and the indurated or infecting.
2. Each of them propagates its own species.
3. The soft chancre originates in the inoculation of an infecting chancre upon a syphilitic person.

He endeavored to explain the last point by means of some observations and experiments, which according to the views of our day must be otherwise explained. Reasoning upon this theory, he denominated the soft chancre chancroid.

However, as impairing the worth of these views, there had been detailed in Ricord's *Leçons sur le chancre*, cases in which Clerc's chancroid had produced infecting chancre, and was there furthermore demonstrated that under ordinary circum-

stances it was impossible to reproduce infecting chancres upon syphilitic persons in the form of soft sores.

In explanation of these conflicting facts, Rollet, of Lyons, during the years 1858 and 1861, brought forward the theory of mixed chancre (*chancre mulet, chancre mixte*). He affirmed, adducing as proof numerous observations and experiments, that those ulcers which produce both forms are the result of a double contagion, to wit: that in a given spot coincidentally have been inoculated the chancre-virus and syphilitic contagion.

Although at first impression this theory seems far-fetched, it gains more and more in simplicity and probability, as we proceed to consider it. The reason why it was not immediately adopted by the medical world was that some other French authors, especially Diday, had surrounded it by a labyrinth of nomenclature. But soon, when closer attention was paid to the subject, more careful observers took up the matter and brought order out of chaos.

Prominent among them was Zeissl of Vienna, who with praiseworthy acumen and great simplicity, differentiated the various forms of ulcers.

But Rollet, the originator of the view, had already clearly and concisely described them in his excellent works: "*De la pluralité des maladies vénériennes*," and "*Recherches cliniques et expérimentales sur la syphilis, le chancre simple and la blennorrhagie*," published in 1861. He differentiated the two forms of ulcers from various points of view.

(1) From experimental inoculation upon the bearer or auto-inoculation; (2) from the various course of the ulcers; (3) from the sequelæ which they produced upon the organism; (4) from the source of contagion; (5) from the therapeutics. Considering the first point, he demonstrated that soft chancre has an almost endless power of auto-inoculation, while the infecting ulcer in any of its stages can not be propagated upon its bearer, or other syphilitic persons. Exceptions to this rule, of which Rollet was cognizant, will be treated of further on. Clinically considered, the soft chancre, as a rule, appears mostly on the genitals, while by far the greater number of those situated upon other parts of the body are syphilitic chancres. Detailing the difference in the course of the ulcers, he called attention to the fact that the simple chancre has no period of incubation, while the syphilitic manifests itself in the minimum, nine, in the maximum forty-two days, in the medium three weeks after contagion. The simple chancre begins as a pustule

at the site of inoculation ; the syphilitic as a papule, which ulcerates later on.

Reverting to the sequelæ of the two forms of ulcer, it is evident that after simple chancre no lues is developed, while the infecting ulcer is only the first symptom of general infection. The duration of the incubation of the lues, Rollet fixes in the minimum of twelve days, in the maximum of one hundred and twenty-eight, in the medium of fifty-two days.

Regarding the source of contagion, he alludes to the above quoted instances of confrontations of Bassereau, which are conclusive.

Speaking of the therapeutics, he showed that local treatment invariably cures simple chancre, while the syphilitic ulcer, at the most, is only locally benefited by it, and constitutional contamination is never prevented. Furthermore, that mercurial treatment, which is so beneficial in syphilitic chancre, modifies for the worse the course of the soft sore.

Rollet arrived at the theory of the mixed chancre by the following reasoning, which he verified by observations and experiments :

Suppose a syphilitic person acquires a soft chancre : if the pus of this soft chancre is inoculated upon a healthy individual, the result is the immediate development of a soft chancre, which perhaps may remain a local lesion ; but if at the inoculation blood of the syphilitic person has been transmitted with the chancreous pus, then there follows a double contagion ; 1st chancre-contagion, 2d, secondary syphilis-contagion, transmitted by the blood. Now, as syphilis has a prolonged period of incubation, and as furthermore its first symptom, the papule or nodule appears, as in chancre, at the point of inoculation, one might suggest that the subsequent induration of the base was a modification of the chancreous ulcer, while in fact they are distinctly separate pathological processes, which by chance develop upon the same spot. To suppose another case : a syphilitic person acquires a soft chancre in the vicinity of a specific sore. The pus of the two forms becomes mixed ; and should inoculation upon a healthy person occur from this combined contagion, it is followed precisely by the result above detailed.

Rollet affirms that one of the species of chancre described by Carmichael, besides Rayer's *ulcus elevatum* and Ricord's "*chancre induré ecthymateux*" should be classed as mixed chancres.

The statistics of the *chancre mulet*, as compared with the

infecting variety, have a ratio according to Rollet of 5 to 100, according to Puche and Fournier, of 2 to 100.

As the vehicle of the contagion of simple chancre, Rollet considers only the pus-corpuscles and not the serum; but the virus of syphilis permeates every tissue and fluid of the economy, the primary ulcer, the blood, the serum, the sperm, etc. He explains the systemic immunity after the soft chancrous ulcer by the fact, that the large corpuscles of the pus, which form the only vehicle of its contagion, are impermeable to the capillaries.

The syphilitic poison is reproduced and augmented in the organism itself after the primary infection, and therefore the therapeutical indications are not to dilute or remove, as in mineral and vegetable poisoning, but to completely annihilate.

The views of Rollet very soon became prevalent in France, especially as they were endorsed by Ricord. But very few adhered to the old theory, among them Vidal, Melchior Robert and Langlebert.

In America the dualistic doctrine was introduced by the very excellent book of Bumstead, which by its admirable clearness of argument and diction, and comprehensiveness of scope, produced a general adoption of the new ideas among the profession; and as far as is known, only a few physicians, among whom Professor Gross, of Philadelphia, still adhere to the old theory.¹

In Germany, the dualistic doctrine met with a similar good reception. The first adherents of distinction were von Bärensprung and Zeissl, while Sigmund only adopted it in 1862, and even then with some reservations. Hebra, Michaelis, Auspitz, Köbner and others remained unconvinced unicists, and their objections are now our main consideration.

The very first decided opponent of dualism was Vidal (de Cassis), who, shortly after the appearance of Ricord's letters and Bassereau's first work, published his "*Traité des maladies vénériennes*," in which he violently opposed the views, tending to the separation of the different venereal contagions. Vidal acknowledged but one contagion, which also is the origin of gonorrhœa, and denied *chancre larvé*. Even venereal vegetations he claims as a constitutional syphilitic symptom, and regards all, primary and secondary lesions as transmissible. A general infection precedes always the evolution of the chancre,

¹ Since the above was written, the number of adherents of the doctrine of unicism has been increased by Dr. Maury, of Philadelphia, who confesses himself convinced by the observation of one case.

as well as of the gonorrhœa; a distinctly drawn line of demarcation between indurated and soft chancre does not exist; the two forms imperceptibly merge the one into the other, and the induration is not essential to the development of general symptoms. Vidal likewise advocates the existence of *bubon d'emblée*, which is developed without any primary affection by the so-called physiological absorption. Mucous patches, according to him, show themselves upon mucous membranes and neighboring regions, due to all sorts of uncleanness, and are the first symptoms of syphilis after gonorrhœa and chancre; they are always inoculable upon the bearer, and in this respect form one of the main objections against dualism. This circumstance was also the principal drawback to Sigmund from joining the new theory, and only when the dualists claimed it as conforming to their views did he decide in their favor.

The experiments which were made by Hebra to settle the matter are hardly worthy of close consideration, as their results are claimed both by unicists and dualists as favorable to their views. The main reason for this indecision rests in the circumstance, that in some sources of inoculation mixed chancre was not eliminated with sufficient care, especially in one case, in which upon syphilizing, a great number of inoculations took, and yet a pustular syphilide followed. In a later article in the *Allgemeine Wiener Medicinische Zeitung*, of 1861, number 29, he expressed himself as convinced of views similar to those of Vidal. The presence of primary soft sores is also, according to him, the consequence of systemic infection. Hebra relates a very interesting case in support of his views, in which a syphilitic child infected his nurse; the infection showed itself on the nipple in the form of a typical soft ulcer, which at the test of inoculation gave positive results, and yet constitutional lues followed.

With the exception of Hebra, Michaelis stood almost alone in Germany, as an advocate of the unity of syphilitic virus. In the second edition of his compendium of the doctrine of syphilis, Vienna, 1865, he annunciates a number of aphorisms, from which we select the following:

1st. If the secretion of a hard chancre is inoculated upon a healthy person, in the majority of cases a hard chancre follows; or, 2d. The point of inoculation heals with a soft cicatrix, and induration of neighboring lymphatic glands takes place; in very rare cases general infection follows directly, without any primary manifestations. 3d. A soft or indistinctly characterized ulcer is the consequence; this is the rule in females.

4th. The secretion of hard chancre, when allowed to undergo fermentation, acts like the putrid secretion of any ordinary wound. 5th. A soft chancre from a syphilitic person, inoculated upon a healthy one, generally produces a hard ulcer. 6th. From one and the same source of inoculation the different forms of chancre are produced in different individuals. Michaelis says of these aphorisms, that they are the result of numerous experiments, but without giving any details. Induration according to him, is a new formation of connective tissue, a nodule of resorption, which is formed always around masses of exudation, and which later on undergoes fatty degeneration. It is not confined exclusively to the infecting ulcer, but also is found in the soft sore, and even in non-contagious ulcers.

Before we proceed to the most important objections to the dualistic theory, namely those of Bidentkap and Köbner, we will briefly state that the auto-inoculability of secondary ulcers and mucous patches had certainly been proved. Of the mucous patches or condylomata lata, clinical observation had demonstrated the fact long ago. For the other syphilitic symptoms, as pustules, hard chancres, etc., we have the observations and experiments of Ricord, Vidal, Cazenave, Puche, Velpcau, Boeck, Michaelis, Faye, Henry Lee and others.

The adversaries of dualism, however, found in Boeck's experiments of syphilization their main support, as the following fact had been discovered. When a syphilized person had obtained an immunity for a portion of his body, or a temporary, or in some cases even perfect immunity, they succeeded in drawing a positive result of inoculation by altering the method, especially by irritating the source of inoculation with such vesicants as croton oil, pulvis sabinæ, tartar emetic, etc. In consequence of this observation, Bidentkap, under Boeck's supervision, instituted a number of experiments of inoculations upon syphilitic persons, which became very important to the doctrine of the double contagion. The result of his nine experiments, made with a lancet upon the bearers, Bidentkap condenses as follows :

1st. Inoculation of indurated infecting chancre upon the bearer seldom took immediately, more generally did not take, or gave rise only to abortive pustules.

2d. If by external irritation the ulcers had been caused to suppurate more profusely, the inoculation produced pustules in the majority of cases.

3. These pustules could be propagated in continuous series, which, according to Bidentkap, proves that they were soft

chancres ; in one case they were accompanied by indolent buboes.

Bidenkap, therefore, arrives at the conclusion that the soft chancre can be produced by inoculation of syphilitic ulcers upon syphilitic persons, and that therefore they owe their origin to the same contagion as constitutional syphilis.

Still more important, by reason of their minuteness of detail, are Köbner's experiments, published (1864) in a small volume (*Klinische und experimentelle Mittheilungen aus der Dermatologie und Syphilidologie*). He has irritated the different ulcers to a greater extent, or, as he says, he has concentrated or diluted the pus according to his wishes. These are his results :

The inoculation with the serous secretion wanting in pus corpuscles of the red, smooth or finely granulated surface of an infecting chancre fails in almost every instance, or gives rise merely to small pustules, which soon disappear without treatment. But should a more copious suppuration be induced upon this surface, either by mechanical or chemical irritation, the results of inoculation are positive, in the form of a pustule, which appears within from forty-eight to seventy-two hours, and which is transmissible in several series, sometimes even as many as twenty upon its bearer. All auto-inoculations, made with the pus of ecthyma, rupia, pemphigus syphiliticus neonatorum, or disorganized gummata, etc., failed ; while upon the same persons fresher or more concentrated pus, originating likewise from secondary lesions, showed great capability for the production of extensive ulceration. If the pus of soft chancre is diluted, the period of inoculation can be prolonged to five days, and by still greater dilution, its inoculability is annihilated.

Köbner epitomizes, as the result of all his experiments, that the soft chancre is an acute inflammatory manifestation of syphilitic contagion, while the constitutional form represents a modification of the same with a milder and more chronic character.

Bidenkap's and Köbner's experiments fell like a bombshell among the dualists, causing a great number of desertions from their ranks. Some of the most prominent dualists recanted, and among them we may mention Reder, professor of venereal diseases at the Military Medical Academy of Vienna, who previously a zealous dualist, in the last edition of his creditable work on venereal diseases, published in 1868, pronounced dualism a complete failure. Bärensprung, Kraus and Pick endeav-

ored to render futile Bidentkap's and Köbner's experiments by showing, that upon syphilitic persons auto-inoculable ulcers could be produced with ordinary pus, as for instance, that of pustules of scabies, provided the pus was rendered rich in corpuscles ; or, as Köbner expresses it, concentrated by irritation.

But to this interesting fact the experimenters simply replied, that upon a syphilitic soil, under the influence of the syphilitic contagion, even this, if we may so call it, healthy pus could be altered into chancreous matter, which fact would give more weight to the view of the unity of the two viri.

If now we are to confess, that by reason of Bidentkap's and Köbner's experiments dualism has been almost pushed to the wall, their arguments, nevertheless, fall short of the complete demolition of the doctrine. Dualists, upon close consideration, might find in them even confirmation of their tenets. Apparently they do not prove anything else than the auto-inoculability of secondary lesions, which fact has long been known, especially that of the auto-inoculability of the secretion of mucous patches. Also multiple indurated chancres had been observed, and yet neither of these facts militated strongly against the dualistic doctrine. The fundamental principle of this doctrine is expressed in the fact, that a soft chancre inevitably and solely produces a local, simple chancre, and that indurated chancre and other syphilitic lesions inevitably produce constitutional syphilis. Or, more concisely stated, that each species begets only its own kind. Whatever variations may occur in the course and character of one or the other of the affections, they do not controvert dualism, so long as both forms do not merge the one into the other. Before dualism falls, one question must be settled, to wit : What is the result of Bidentkap's and Köbner's auto-inoculable ulcers, when transmitted to healthy organisms. If they there propagate syphilis, then they do not prove any thing against dualism, because they then only propagate their own species, but if they produce *local* auto-inoculable ulcers, or true soft chancres, then they would be definitely conclusive of unicism.

What has been developed thus far, does not favor the views of unicism. We revert to Hebra's case already quoted, page 204, in which syphilis followed a typical soft auto-inoculable ulcer of the nipple, the contagion of which was communicated by a syphilitic suckling. We might also quote Vidal's experiments (see page 226), in which a syphilitic pustule of the left breast propagated auto-inoculable ulcers, which gave rise

to constitutional syphilis. To our knowledge, further observations in this direction have not been published. But as they propagate constitutional syphilis, they have certainly more weight *for* the separation of the two contagions than against it. They merely show that to the already innumerable pathological forms of lesion, produced by the virus of syphilis in the organism, we must add a new lesion, namely the auto-inoculable ulcer. Only if the adversaries of dualism, as already stated, should succeed in producing from these ulcers indubitable local chancres upon healthy subjects, then theoretically dualism would fall to the ground, and only from a clinical point of view would be held in any esteem. Meanwhile we scarcely look for this contingency, and, without modifying our views, may patiently await the turn of events. We are informed by Prof. Boeck, that he is under the impression, that Bidentkap has recently succeeded in producing these chancres, but full details are necessary.

It now remains to bring forward a few facts of minor importance in support of dualism, which have not as yet been mentioned :

The one is the discovery of Auzias Turenne, that simple chancre is transmissible to animals, while constitutional syphilis is not. Numerous experiments have been instituted by him, as well as by Ricord, Langlebert, Robert v. Welz, Diday, Melchior Robert and others, with the same unvarying result. They frequently succeeded in transplanting soft chancres upon dogs, cats, rabbits, etc., and these chancres were reinoculable upon man. But systemic syphilis thus far has not been observed in animals. Auspitz relates a case of a rabbit, upon which Rosner, by the inoculation of syphilitic virus, was said to have produced a general scaling eruption ; but as Rosner himself does not mention the case in any of his various articles, it seems to be an error, or a coincidence. Truly the weight of this fact is in favor of dualism.

Another observation supporting dualism is the following, which is historical : Previous to the outbreak of syphilis in the army of Charles VIII., at Naples, about 1495, no medical author of middle age or antiquity even mentions this disease as such, while numerous quotations show the frequency of contagious ulcers of the genitals. This fact was brought forward at the beginning of this review, and Bassereau found in it the chief support of his new doctrine. We will dispense with historical quotations, as there are numerous works published, in which all the data are collected ; but will simply

mention, that, after having reviewed the various numerous passages of old authors of every tongue, we perfectly acquiesce with Geigel, who says, that if syphilis was supposed to have existed, numerous statements and descriptions could be regarded to conform to it, but that none of them were conclusive and powerful enough to prove just this existence of the disease.

Much more important is the circumstance, that at the time of the outbreak of the epidemic, all contemporary physicians unanimously spoke of a *morbis novus et inauditus*. How could it be possible that the typical course of syphilis, which is nearly always the same, should have escaped the acuteness of the old medical men, who in other respects were such close observers, while after the year 1495 it was at once apparent to everybody. To believe that, one would be obliged to accept the statement of Michaelis, who says that the unprecedented morality of the Christian middle age, when the lusts of the flesh were destroyed, and poets only sang of platonic love, had made syphilis so rare, that it hardly came within the observation of medical men. Other authorities, however, entertain a different view of the morals of the middle ages.

Without detailing the different opinions held about the origin of the lues-contagion, we may briefly state, that, for our part, we believe in the American origin of the disease.

Finally, we repeat, that although these might, perhaps, be the last words written in favor of dualism, we should not yet give up its cause.

The reproach of far-fetched explanations given to the dualists by the unicists reverts to themselves. So simply and naturally the double contagion explains the different forms, that even after the fall of dualism, should that event occur, clinically the differentiation would be perpetuated. And what can be more far-fetched than the theory of Köbner and Bidentkap and their followers, who declare the simple chancre to be the acute inflammatory form, and general syphilis, with its pernicious consequences, to be the mild and chronic form. What again can be more overstrained, than the explanation of another unicist, namely, Professor Dittrich, of Munich, who in a recently published article says, that there was a great gulf between experiment and clinical observation, and that soft chancre, which at experimental inoculation always remains local, was, when transmitted by coitus, made constitutional or infecting by means of an electrical phenomenon produced by that coitus. The chancre thus, if we may say so, is, ac-

according to him, telegraphed into the system, to produce syphilis, the coitus acting as the electrical battery. We can only regard these as desperate efforts to uphold a theory, which of itself offers to the practitioner no advantages over dualism.

Until more conclusive proofs are adduced by the unicists, we recommend to our readers Zeissl's proposition, to withdraw the name of chancre, even with an explicative adjective, such as hard or infecting, from all forms of ulcer, which are regarded as the initial or secondary lesions of constitutional syphilis, and to reserve it for the local contagious ulcers only.

FREDRICK ZINSSER, M.D.

Selections from Foreign Journals.

ON THE INDURATION OF CHANCRES IN THE
FEMALE.¹

BY ALFRED FOURNIER,

Médecin des Hôpitaux, Professeur agrégé à la Faculté de Paris.

TRANSLATED FROM THE ANNALES DE DERMATOLOGIE ET DE SYPHILIGRAPHIE,
BY DR. R. W. TAYLOR.

DOUBTLESS you have more than once heard it said that chancre in woman does not become indurated ; that there can be no comparison established, in frequency or in degree, between the induration of chancres in men and in woman.

Here is one of those prejudices which, arising no one knows where, innovated into science by no one knows whom, makes its way, is handed down from generation to generation, and finally is classed with well demonstrated truths. I know of no error more radical in the whole range of pathology. It is a monstrous anti-clinical heresy.

Induration is not produced in woman, says one ; it is only very rarely and exceptionally found in them. To this assertion I make the most formal denial, and I reply, in the name of clinical truth, by the following proposition :

Induration is common in the female, even more common than in men ; it is so frequent in this hospital that we meet it every day, and it constitutes a diagnostic difficulty of a special kind, of which I will speak.

Induration, in fact, is not only a character, an indication of primitive syphilitic infection, it belongs not only to the chancre ; it is also, perhaps more often, a manifestation, an expression of syphilis in a late stage of its evolution. Thus, at one of our early meetings, I will describe to you a series of accidents, very common in the female, consisting in indurations, which accompany or complicate certain late lesions of the diathesis (secondary indurations). Now, not only in this hospital

¹ A clinical lecture delivered at the Lourcine Hospital.

do we observe induration with chancre, as in men, but in addition, we meet it also coincidently with secondary syphilitic lesions. These secondary indurations, rather rare, or at least not common in men, are excessively frequent in women. One great difficulty is, in these cases, in which we observe indurated vulvar ulcers, to determine whether they are indurated chancres, or syphilides masked by secondary induration. Scarcely a week passes in which we do not observe this particular diagnostic difficulty. So that, far from having to exceptionally decide upon induration, we are called upon every day to observe it, and we are constantly on our guard against the errors to which it might lead us.

Cases of primitive and secondary induration in women are so frequent, that I could place hundreds of them for your observation. Our record books are filled with them.

Let me speak now of primitive chancrous induration. This, says the old prejudice, is very rare in women; it is not developed in her as in men. Let us see what such an assertion is worth. To that end, let us not hesitate to stoop to details; let us follow the chancre in the female in all the localities in which it is found; let us examine scrupulously whether, upon any of the sites in which we will have to study it, it is attended with a specific induration.

I. In the first place, chancres have sites common to men and women; in other words, chancres in women have their representatives, their homologues in men; chancres of the lips, of the tongue, face, eyelids, fingers, arms, thighs and trunk, and even chancres of the breast. For this first group of accidents a vigorous comparison should be made between the sexes as regards the question which now concerns us. Let us haste to institute it. What do we find? On the one hand, in all observations upon extra-genital chancres in women, induration is mentioned as one of the characteristic features of the lesion. Everywhere, it is stated in the most explicit manner, that lesions, regarded as chancres, present a base indurated, hard and cartilaginous, etc. In many cases the presence of this induration, under a suspicious ulceration, has led observers to recognize and diagnosticate a chancre.

And, on the other hand, let us consult our constant criterion; I refer to the facts of experimental inoculation. In the details of six cases of inoculation in women, we find the presence of induration mentioned in five of them, and these cases correspond in all particulars with similar ones in men, for the experimenters mention no difference in the aspect or characters of the lesion. More than this, it has been thought that

the induration of extra-genital chancres was sometimes more marked in women than in men. You exclaim that it is a fore-gone conclusion, or my exaggeration; but I will convince you by citing the words of other observers.

M. Clerc¹ says: "Chancres of other regions than the genital have presented to our observation induration as often in women as in men. There are, in women, certain regions in which induration is often greater and better marked in women than in men. Thus the labial chancre is often more voluminous, thicker, and in fact more indurated in women than in men. We will say as much of chancres of the orifice of the urethra."

M. Rollet,² speaking of chancres of the breast, says: "Induration of these chancres is generally well marked, sometimes chandroid, at other times simply parchment-like. There are cases reported in which it persisted after cicatrization of the chancre; so that it can be said that the breast is one of the regions in which induration is best characterized." I will not press the subject further,³ but make the general assertion that the induration of extra genital chancres is developed equally in both sexes, if not even in greater degree in some regions in women. Here is the first point gained in the controversy.

II. In the second place we come to genital chancres. It is the denial of the induration of these which I actually criticise. Let us consider, clinically, a clinical question; let us examine each chancre individually, and see what usual form it assumes in the special point of view which concerns us.

1. Upon the labia majora, the syphilitic chancre is always indurated, and almost always strongly indurated. It is there, according to most observers, that induration develops itself in a manner most pronounced. It is not rare to find these deep indurations constituting veritable callosities, offering the resistance of cartilage, I would almost say ligneous hardness. On referring to my notes upon the subject, I find more than thirty cases reported by my internes, in which chancres of the labia

¹ *Traité pratique des Maladies Veneriennes.* Paris, 1866. Page 68.

² *Traité des Maladies Veneriennes.* Paris, 1865.

³ I have designedly said nothing of chancres of the anus. In women, as well as in men, it is often very difficult and almost impossible to perceive the induration on account of the local conditions, such as the tension of the tissues, the normal resistance of the sphincter, the situation of the chancre, so that a person cannot succeed in seizing and isolating it, as the base slips away when carefully examined. All that can be said of these chancres, as pertaining to the question in point, is, that their induration is or seems to be nearly equal in men and in women, and that no difference can be established between the sexes.

majora have been described as follows : "Chancre offering a ligneous induration ; chancre marked by an enormous induration, constituting a lump with a hardness comparable to that of cartilage ; chancre with induration which would lead a person to suppose he felt a pebble between his fingers (*sic*)," etc. What will the advocates of the non-induration of chancres in the female think of these expletives ?

2. Upon the labia minora, induration of chancres is not less common, but it there more frequently affects another form, the flattened laminated form, called parchment-like or leaf-like. It is very common, however, that the whole labium minus is the seat of chancrous induration, and then resembles a rigid resistant lamella of singular hardness. I am happy to be able to show you a case of this kind. This young woman entered our wards some days ago, affected with a chancre of the left labium minus and a corresponding inguinal pleiad. In the first place you see this little lip which stands saliently out of the closed vulva, which I open, and a chancre upon its internal aspect is to be seen. This lip presents a curious appearance ; it holds itself straight and erect, everted as if we exercised traction upon it ; in truth, it is very much distended by an exuberant induration. Touch it, you will be astonished to find it so hard ; without exaggeration, it presents the hardness of cartilage. It would not offer a better marked resistance if it was cartilage.

3. Upon the prepuce and glans clitoridis the chancre, it is true, is merely an erosion, scarcely parchment-like. But in other cases, which are far from being rare, we observe profound induration in masses and lumps converting the whole space into ligneous nodosities. You have an opportunity to judge of it. This other patient has a chancre which covers the glans clitoridis, and involves besides the prepuce a part of the upper portion of the labia minora. The prepuce and labia minora give already a resistance strongly parchment-like. Seize the prepuce and roll it between the fingers, and you will feel below it something excessively hard, giving a sensation of a rod of steel, of a "ram-rod," following the simile of one of my students. It is the clitoris indurated in an extraordinary manner.

4. Chancres of the urethra and meatus urinarius present an induration no less pronounced. M. Clerc has said of them, "that these chancres are often more voluminous, thicker, and in short, more indurated in women than in men. *The most typical examples of induration of chancres of this region, according to our observation, are met with in women.*"

5. As to the chancres of the neck of the uterus, their inaccessible situation does not allow in general of careful examination of their bases. In certain cases, however, I have remarked in a most positive manner that the portion of tissue, upon which they were seated, was thick, voluminous, salient, and deformed as if distended by an exuberant infiltration, and the finger pressed upon the organ experienced a very appreciable sensation of hardness. M. Ricord had the opportunity of observing one of these chancres in a woman having prolapsus uteri; the neck, in this condition, could be seized between the fingers, and as delicately examined as the summit of the glans. The base of this chancre presented, says our master, a peculiar induration, cartilaginous, almost ligneous, which was well defined and was easily differentiated from the normal resistance of the uterine neck.

6. Finally, I arrive, in this review, at a group of chancres, the induration of which, it must be confessed, is often badly marked, or with difficulty appreciated. They are the chancres of the fourchette, of the fossa navicularis, of the vestibule, of the carunculæ myrtiformes, of the ostium vaginæ, in a word, of the vulvo vaginal infundibulum.

Upon the fourchette induration is rarely developed as a nodule; more frequently it is flattened, laminated, and parchment-like. It is with difficulty felt, because this region, contrary to what might be supposed, is not easily examined. On this site, however, with a little care and practice in the majority of cases, it may be appreciated. But the difficulties of examination increase, and the induration becomes less appreciable as we pass from the external portions of the vulva towards the vagina.

Upon that portion of the vulva situated within the labia minora (the periurethral region excepted), upon the fossa navicularis, the ostium vaginæ, and more especially the carunculæ myrtiformes, it is rare to find induration clearly and strongly defined. Chancres of these parts are remarkable for several particulars; in that they are in most cases of limited extent, and are almost always simple erosions, desquamating rather than ulcerating; that they have a rapid evolution and a short duration, and finally, in the point of view which concerns us, they are simply lined with a very delicate lamella of induration, at the most, parchment-like. It is undoubtedly upon these sites that the syphilitic neoplasm, which constitutes induration, is developed most sparingly. Now, to add to our perplexity, it is upon these sites also that the study of induration is surrounded by the greatest difficulties, by reason of the local conditions.

In the first place, we cannot easily seize and examine the base of these chancres, as they slip from the fingers, and then we cannot succeed in isolating and detaching them from the subjacent tissues ; they truly hide away from examination. There are, then, I repeat, such difficulties of examination that, with the best intentions in the world, we are often forced to give the matter up. This is so true, that in a large number of observations taken at the bedside of the patient, I find the fact noted in the following terms : Chancre of the ostium vaginae it is impossible to feel its base, chancre of the earunculae with an inaccessible base, etc. Thus two conditions are combined to render the diagnosis of induration difficult. First, upon these parts the syphilitic neoplasm is most scantily developed, and under the least distinct form ; second, the condition of the tissues of these parts render the examination and perception of this sign very difficult, often indeed impossible.

Let us recapitulate :

1. Induration is developed in women as in men, even more frequently in women, if we include with the primitive chancrous induration the secondary indurations which, though common in women, are comparatively rare in men.

2. Speaking only of primitive induration, the extra-genital chancres, which furnish a rigorous standard of comparison between the sexes, are in the same degree and manner indurated in women as in men.

3. Certain chancres in women present, in the great majority of cases, an equal and sometimes greater induration than similar chancres do in men.

4. There is only one region, and that limited to the genital organs (the vulvo-vaginal infundibulum), in which induration is developed more sparingly in women than in men ; and here local conditions render examination difficult.

From this comparison, judge whether I was warranted in stigmatizing this singular opinion as an anti-clinical heresy ; whether it was a worthy purpose of ridding pathology of this old and ridiculous prejudice.

However, let us not exaggerate, and after having refuted an error, let us not ourselves overstep clinical teachings. Although induration can be and is developed in women in a great number of cases in a manner absolutely identical as in men, it is not less true that there are differences of a secondary degree presented between the sexes ; of these two are to be noted.

1. *Superficial* induration is more common in women than in men ; that is, those flattened, laminated indurations, which

have been compared of flat disks, to quoits and washers of parchment, are more often found in women.

2. Induration in large, well-defined nodules is certainly rarer in women than in men ; and what conduces to make it appear rarer is, that in women true chancrous induration is frequently surrounded by induration of another kind, of which I will speak hereafter.

In this point of view there is a curious difference to be noticed between the two sexes. In man the chancrous *callus* exactly lines the chancre without perceptibly encroaching beyond its limits, and the tissues which surround it usually preserve their normal suppleness. In women, on the contrary, there is an indurated zone of greater or less extent developed around the primitive chancrous nodule. Thus, I have already had the opportunity of showing you chancres even limited and superficial, which had converted a labium minus into a cartilaginous lamella, and the whole of a labium majus into a resistant mass of extraordinary volume and hardness. In cases of this kind, you understand that the primitive induration disappears, blended as it is with a gangue of peripheral induration, from which it is impossible to distinguish it. It is very liable to be confounded with lesions of another class, and I have but little doubt but that in such conditions it has been more than once unrecognized.

Epitome of Current Literature.

On the Transmission of Syphilis to the Nursling by the Nurse.—Dr. Achille Dron calls attention to a peculiar and insidious means of syphilitic infection of nursing children, which is produced as follows: A nurse, having suckled a syphilitic infant, for some reason, as perhaps the death of the child or her dismissal, leaves it. The secretions of the child's mouth, which is the seat of mucous patches, have infected the breast of the nurse; but as syphilis observes a period of incubation, the initial lesion is not for some time apparent. During this period she may perhaps give the breast to another infant, and, while nursing it, the initial lesion of syphilis shows itself in the shape of a fissure, which becomes indurated, or an indurated papule with an excoriated secreting surface. As very similar lesions of a benign character are very frequently met upon the nipple, little or no attention may be paid to it, as its origin is unsuspected, and, as a consequence, the second child in its turn is infected. It is obvious that during a period of incubation a most thorough examination would have failed to reveal any symptoms of syphilitic infection in the nurse, and if interrogated as to the condition of the child which she had previously nursed, the responses might be unsatisfactory, even if the nurse spoke in good faith. And when the initial lesion has become of such proportions, being then accompanied with axillary adenopathy, that attention is called to it, the child is almost surely infected with syphilis. M. Dron relates twelve cases in which a chancre appeared on the breasts of the nurses after they had ceased nursing syphilitic children. He also reports a second series in which, after the appearance of the chancre, they nursed other children which became syphilitic.

Case 1. Marie M., 22 years of age, was delivered of a healthy child which, having nursed eight months, she took another infant fifteen days old, and nursed it until its death. Previous to that event, however, the child was affected with a very copious eruption of pemphigus and mucous patches in the mouth. At the child's death the nurse had no lesion upon the breast, but three days after an ulcer appeared upon the left nipple, which was soon accompanied by axillary adenopathy. Two

months after she had mucous patches upon the vulva, and other secondary phenomena. As a consequence, her husband soon discovered an indurated ulcer upon his prepuce, which was likewise followed by secondary manifestations. Their infant also became syphilitic, probably from the mother's breast. They were submitted to treatment and cured.

Case 2. Jeanne D., aged 44 years, was given, at Charity Hospital, Lyons, an infant 24 days old, which she nursed. Eight days after the child had mucous patches in its mouth, and other syphilides on its body. Jeanne nursed it six weeks, when it died, covered with very large pustules. Eight days after its death the nurse observed an ulcer on the left nipple which, in due time, was followed by secondary symptoms. Some time after this she was delivered of a very thin child, which died in eight days. Her husband became syphilitic, and two other young children died of syphilis, and the nurse, who took care of the latter, also became syphilitic.

Case 3. Victorine L., 36 years of age, weaned her fifth child, and took an apparently healthy child, aged ten days, to nurse. Fifteen days after that, mucous patches appeared in the mouth, which were merely regarded as *muquet*, there was besides an eruption upon the body. The infant lived six weeks. Eight days after the child's death the nurse noticed a papule upon her nipple, and very soon after the ganglia in the axilla enlarged. The papule became ulcerated, and existed seven weeks. Secondary symptoms appeared, which were treated by a mercurial.

Case 4. Marie Mondière, a cousin of the subject of the first observation, presented herself at the hospital in October, 1869, with well-marked secondary symptoms. In the previous July she had taken a little girl to nurse, which one month after presented secondary syphilitic lesions, and which soon died. Eight days after the child's death she noticed a small fissure upon the left breast, which indurated. Secondary lesions soon followed it.

Case 5. Anne Gilles weaned her child in January, 1853, and took a very frail female child, aged two days, to nurse, which soon presented syphilitic phenomena and died. The nurse observed an ulcer on her nipple fifteen days after the child's death, which ran a very sluggish course. Secondary symptoms followed.

Case 6. A nurse was selected to suckle an apparently healthy child which, however, in three weeks presented secondary symptoms. She was ordered by her physicians to cease nursing the child, but she did not obey them. The child died, and fifteen days after that event the nurse noticed a papule upon her nip-

ple, which ran an indolent course, and was followed by syphilitic manifestations.

Case 7. A child was born of syphilitic parents ; one month after its birth it was covered by various syphilides. The nurse gave it the breast for some time after the appearance of these symptoms, and three weeks after leaving the child had a chancre upon the nipple, followed by regular evolution of secondary symptoms.

Case 8. Antoinette Peyronnet took charge, as nurse, of a feeble child, which about three weeks after presented mucous patches upon the lips, followed by a general eruption, and it shortly died. The nurse developed primary and secondary manifestations of syphilis.

Case 9. Marie P., fifteen days after parturition, took charge of a child five weeks old, which had papules upon forehead, nose, and in mouth. She was suspicious of the character of the eruption, and, by the advice of a physician, she ceased to nurse it, but had done so for four days. About one month subsequently, she observed the initial lesion of syphilis upon her breast, which was the forerunner of a general eruption.

Case 10. J. B. took charge, as nurse, of a seemingly healthy child, which soon developed syphilitic manifestations ; the nurse had an indurated ulcer upon the nipple, followed by syphilis.

Case 11. The mother of six children, after nursing her last child for a year, she became the wet-nurse of a child, at the Charity Hospital, Lyons, which had a papule on its body, and was ill-nourished. It developed secondary symptoms and fissures at the angles of the mouth, and soon died. The nurse, after the child's death, observed an indurated ulcer on her breast, which was followed by secondary symptoms.

Case 12. A woman having previously enjoyed good health, and mother of three healthy children, took charge of an infant at the hospital. The infant, which was very thin, had an earthy complexion and an old look, and soon developed secondary lesions, prominent among which were mucous patches. The child died, and the nurse had an indurated ulcer upon her breast, which was the forerunner of syphilis.

The second series of accidents reported by M. Dron, differ from the first in the fact that during the period of incubation the nurses take charge of a second suckling, which in due time they contaminate.

Case 1. A woman, having lost her infant, became nurse of a little girl at the Charity Hospital, which had an eruption around its eyes. It soon developed secondary symptoms and

died. The woman was then examined by the inspector of nurses and pronounced healthy, and a second infant in good health was entrusted to her. After the nurse had suckled it eight days, she noticed two indurated ulcers on one nipple, and one on the other ; but she continued the nursing. Five weeks after she had secondary symptoms. Two months after taking charge of the infant she noticed a little rigid crust, a species of cicatrix, upon its tongue. In fifteen days papules developed generally over the body, and it died in a month. The nurse asserted that she was infected by the second child, as her ulcer appeared eight days after having taken charge of it.

Case 2. A healthy woman, the mother of six fine children, became wet-nurse to a child four months old, which had been bottle-fed for the last month, and cared for by another nurse which left it. There is no statement as to the health of the parents or first nurse. The child was sickly, had mucous patches in its mouth, and papules over the whole body. The second nurse suckled it three days and left it. She returned home and suckled her own infant again, and three weeks after her return she noticed papules on the nipples, which were followed by secondary syphilis. The child began to waste away, and became syphilitic.

Case 3. A. Saltarin put her own child to nurse, and took charge of an infant one day old, which already had bullæ upon its body. She nursed this child six weeks and left it, having painful suppurating sores on her nipples. As she had no excoriation on her breasts, fifteen days after she took charge of another infant, and in four days after that two ulcers appeared upon her left breast. These increased in spite of treatment. The mother of the child became alarmed and consulted a doctor, who recognized the lesions as syphilitic, and ordered a cessation of the nursing. The nurse developed secondary syphilis, the child had the initial lesion in its mouth, which it communicated to a second nurse, who likewise became syphilitic.

Case 4. A woman, 28 years of age, was the successor of the nurse, Saltarin. She nursed the baby of Case third until its death, when she assumed a similar position in another family, having no apparent lesion upon her nipples. Fifteen days after this she experienced an itching upon the right nipple, and a week later noticed three papules, which ulcerated. By the order of a physician the nursing ceased, and at that time the infant presented no lesion. The nurse developed secondary symptoms, and the infant became syphilitic.

Case 5. A woman, having a healthy child fifteen months old, kindly nursed a weakly child which in a few days developed

secondary syphilis and died. During this time the nurse had suckled her own and the syphilitic infant. She soon had an ulcer on her nipple, in due time her child had an indurated ulcer in its mouth, and they both had secondary manifestations.

M. Dron remarks that these cases have an important medico-legal bearing. It is not at all improbable that a nurse having become syphilitic by a first child, and the lesion not manifesting itself until some time after her taking charge of a second, that the latter should be fixed upon as the source of contagion. And this evidence very often appears all the more satisfactory, as the lesion upon the nurse's nipple may be so trifling at first as to escape notice until the appearance of a sore in the mouth of the child, and then in the mind of the nurse, who is ignorant of the law of this incubation of syphilis, there can be no doubt but that it is the latter child who has infected her, instead of her having infected it, and she may perhaps demand an indemnification by law. This state of affairs may be very embarrassing to the physician unacquainted with the previous history of the case, who knows how frequently nurses are infected by nursing children, particularly if misled by the father, who whispers in his ear some vague story of a venereal disease of years gone by. The indications are plain—to endeavor to fix the date of the appearance of the lesions in the nurse and in the child ; to establish, if possible, the healthy condition of the parents, and to carefully examine into the history and condition of a previous child which the nurse may have suckled.—*Annales de Dermatologie et Syphiligraphie Deuxieme Année*, No. 3.

Syphilitic Hepatitis.—Dr. A. Rodet, referring to our meagre knowledge of lesions of the liver from acquired syphilis, reports the following somewhat hypothetical case :

A man had a urethral discharge which persisted for six months, when he observed syphilides upon the body, and mucous patches, not having noticed the initial lesion. He was treated for several years with preparations of iodine, leaving off the medicine upon the disappearance of the eruption. In 1866, three years after contagion, he was very much debilitated, and, in consequence, took sea-baths, which benefited him so much that he used them the year following. In July, 1868, he underwent a sudorific treatment with frequent purgation, and at the end of it experienced a fixed pain in the right hypochondrium. This was unsuccessfully treated by blisters. When seen by Dr. R., for the first time, on the 8th of December, he com-

plained of this pain, which he described as deep, dull, and annoying. It was evidently located in the liver, which was enlarged and descended two or three fingers breadths below the false ribs. Pressure upon the free border of the liver was not painful, but when exercised upon the intercostal spaces, produced an acute pain. Hepatic dullness, from above downwards, covered a space of about twelve *centimetres*. There was not, nor had there been, jaundice, the appetite was poor, digestion slow, emaciation, and there was a general want of strength.

Not having then acquainted himself with the clinical history of the patient, M. Rodet treated him for congestion of the liver. In three days he complained of more intense pain, particularly at night, with nervousness, sleeplessness, and febrile movement. This caused M. Rodet to regard the case as one of an obscure malarial origin, but the treatment failed to yield any relief. Physical examination upon the 28th of December revealed the same condition of dullness, and the same intercostal pains as upon the eighth. Interrogated as to syphilitic history, M. Rodet obtained the information given above, which, with the present condition of hepatic engorgement and pain, with nocturnal exacerbations, confirmed him in his diagnosis of a syphilitic origin. The patient was then ordered to take about four grains of iodide of potassii daily, and to anoint the painful spot with iodine ointment. In five days great amelioration was noticed in the pain, and hepatic dullness was less. The dose of iodide of potassi was increased to twice, and then thrice the quantity, with very marked effect, and finally increased by four grains every five or six days. A cure was effected by the 9th of April, and there has been no relapse since.

Three questions are suggested by the case: Was the patient syphilitic? If so, could that diagnosis be arrived at without the previous history? What was the probable lesion of the liver?

There could be no doubt as to the occurrence of syphilitic symptoms a few years before, and it seemed open to question as to whether the pain in the neighborhood of the liver was due to pathological change, the result of syphilis. M. Rodet thinks that as the patient was treated in a desultory manner by the iodide of potassium, that the effect was merely to remove visible symptoms while the syphilitic diathesis remained, and that the repeated purgations acting upon the biliary apparatus excited in the liver an inflammation. And the fact of the nocturnal exacerbations, which were not controlled by quinine, but which speedily yielded to the iodide of potassium, would of it-

self be rational evidence of the syphilitic origin of the lesion. Regarding the diagnosis, engorgement of the liver with nocturnal pain and fever, certainly might suggest, in the absence of a full clinical history, the idea of their being due to malarial cachexia. But the history being made out, the suspicion of syphilis was certainly warrantable, as the result showed.

M. Rodet thinks that as the disease was in its late stage, the lesion was, in all probability, a gummy tumor, which, as it increased in size, produced hyperæmia of the surrounding tissues. —*Annales de Dermatologie et de Syphiligraphie Deuxieme Année, No. 2.*

On the Importance of the Diagnosis Between Leucoderma and White Leprosy.—Mr. Jonathan Hutchinson thinks that besides a diagnosis of leucoderma, from bronzed skin, and pityriasis versicolor, it is necessary to differentiate it carefully from white leprosy. The importance of this diagnosis concerns patients in leprosy districts very materially, as if not made, or they would be classed as lepers, excluded from society, imprisoned in a lazaretto,—or buried alive. Nor is the importance of the diagnosis of less clinical value, as by classing leucoderma with leprosy, false statistics are produced, and it may be, as Mr. Hutchinson thinks, that many of the reported cases of leprosy occurring in inland towns, where the inhabitants do not eat fish, which he is disposed to consider as the cause of leprosy, are, in reality, cases of leucoderma, or perhaps, some other wrongly-named disease. Mr. Hutchinson adduces evidence of the fact, that in India, a skin disease identical with our leucoderma exists, and is there confounded by many observers with true leprosy. This is evident by reading the “Report on Leprosy” of Her Majesty’s Secretary of the Colonies. Leucoderma is very common in England, and in many persons of fair skin is only, with great care, recognized: and the reason why it is said to be so common in Spain, Portugal, the north of Africa, and in some parts of South America, is that the difference between the whitened patches and the dusky skin is so very striking. Mr. Hutchinson thinks that deeply-colored negroes are not as frequently leucodermic as the lighter-colored ones, and remarks that travellers do not very frequently speak of piebald negroes. Mr. Hutchinson’s observations lead him to the conclusion that leucodermic changes are especially likely to happen in those who have experienced great physiological changes in the pigmentation of the skin, as for instance, in those who have become bronzed by the rays of the sun.

In the report above alluded to, it is proved that there is a disease known in India as white leprosy, which is really leuco-

derma ; that the natives now regard it, and always have, as true leprosy ; that it runs the same course there as elsewhere ; and that though some of the physicians recognize the difference between the two diseases, others do not. This confusion arises from the fact that in the anæsthetic form of leprosy there are large patches more or less blanched. This blanching of the skin is a source of great annoyance to the patient, whether it be due to leucoderma or leprosy, as the whitened skin becomes easily scorched and vesicated by the heat of the sun, and if it is merely a leucodermic patch, it may be rendered anæsthetic by this means, and this would tend to link together the two diseases. But upon comparing the clinical history of the two lesions, it is very easy to establish the following points of differential diagnosis :

LEUCODERMA.

Merely an anomalous pigmentation of the skin, not the result of a diathesis or dyscrasia ; is not attended by a disturbance of health, nor is it influenced by climatic peculiarities other than exposure to the sun.

Attacks mostly the back of the hands, the limbs, the trunk, and least of all—the face.

Never has a fatal termination.

Patches are white, absolutely devoid of pigments, and sometimes of a bluish tint ; even pinkish when the circulation is accelerated.

Patches abruptly defined and surrounded by a brownish border.

Patches larger, and have a tendency to circular outline, and are symmetrically distributed.

Skin of enclosed patches of natural softness, not elevated or depressed, and do not desquamate.

Sensation of patches and of their margins is normal.

WHITE LEPROSY.

A disease in which there is marked dyscrasia and evident nerve-lesion. Is endemic in certain localities, and is influenced by climatic peculiarities.

The blanched spots of leprosy occur on all parts of the body.

Tends to terminate fatally in from seven to twenty years.

Patches are more or less blanched ; never as white as in leucoderma.

Not abruptly defined, and merge gradually into a dusky red border.

Patches are smaller, have no tendency to circular outline, and are not symmetrically distributed.

Skin of enclosed patches harsh and dry, and are either elevated and nodular or depressed, and sometimes it desquamates.

The white patches are anæsthetic, and their margins are hyperæsthetic.—*British Med. Journal, April 23d and 30th, 1870.*

Leprosy in the United States.—Dr. Hohnboe, Surgeon to the General Hospital at Bergen, in Norway, made in 1863 a tour of Illinois, Iowa, Minnesota, and Wisconsin, in which States our Norwegian emigrants principally settle. On investigating the leprosy prevalent among them, he came to the following conclusions :

1. There are amongst the Norsk population in North America no instances of leprosy attacking those born in the country.
2. There are amongst the Norwegians who have immigrated, taken altogether, not a few who are now the subjects of leprosy.
3. Most of the leprosy patients were already leprosic when they came over.
4. In not a few cases the leprosic symptoms have had their first outbreak in America. This has happened, however, to those who were adults at the date of their immigration, who had, before coming over, lived in such a manner as to predispose to the disease, and who also had not profited to the same extent as most in the general advantages life in America offers.
5. Leprosy, when imported into America, has, as a rule, a longer and milder course than in Norway, and shows also a stronger tendency to spontaneous improvement and recovery.
6. Life in America will in general avert the outbreak of leprosy, so that many will there remain wholly free, who, according to all estimate of probabilities, would have suffered, had they remained in Norway.
7. Climate has certainly a great share in effecting this change. It is not nearly so rigorous and inclement in America as in Norway, and thus does not make the same demands on the vital powers of resistance.
8. It is probable, however, that the altered mode of life has quite as large a share as climate. The immigrants are, in a general way, far better off than they were in Norway, and others are not under the necessity of exposing themselves so much to the influence of climate, whilst, when the need for exposure occurs, they are better protected.
9. Leprosy will disappear amongst the Norwegian population in the States, or will be found only in isolated imported cases. It will not be transmitted from generation to generation as an endemic disease.

Such are the opinions of a highly-qualified investigator on this important subject. Even if a little sanguine, they are, probably, near the truth; at any rate, they have not as yet been met by any evidence on the opposite side. Their value, as indicating that the duration of the leprosy diathesis under a favorable change of conditions is not without limit, is very great.—*British and Foreign Medico-Chir. Review*, Jan. 1870.

Therapeutical Notes.

On the Treatment of the Complications of the Simple Chancre.—Dr. Gailleton, Ex-Surgeon-in-Chief to the Antiquaille Hospital, makes some suggestions upon the treatment of these lesions.

In inflammation complicating chancre, when the penis has become wedge-shaped from inflammation of its preputial extremity or uniformly enlarged from general œdema and a copious sanguinolent pus exudes from the prepuce, and there is pain, he thinks a more energetic treatment is demanded than that of antiphlogistics, baths and injections, and unhesitatingly recommends either incision or circumcision to render the parts accessible to topical remedies, which he thinks in some cases are not necessary after the incision. He thinks that the fears of danger from inoculation of the edges of the incision are theoretic rather than real, that though they become ulcerated they produce no bad effect. He speaks with an experience of forty cases in which he had no unfavorable results, and his maximum period of cure was thirty-five days, which figures he claims are better than those offered by other modes of treatment.

Hemorrhage complicating inflamed chancres is only surely controlled by an incision, cleansing of the ulcer and then touching the bleeding spot with the actual cautery. The usual methods of injections of astringent solutions, such as the perchloride of iron, &c., are mischievous rather than beneficial, and tampons of lint soaked in strong astringent solutions are powerless. M. Gailleton has treated in this manner six cases, in which the hemorrhage was very copious, in one case even to syncope, and all terminated with good results.

Phagedenic chancre, for which so many remedies are vaunted, the principal of which are the perchloride of iron, the potassio-tartrate of iron, lemon juice, compression by small leaden plates, chlorate of potassa, &c., is sometimes successfully treated by mercurials, though they would with reason be deemed inadmissible in that condition. He cites two cases thus cured. The first case was that of a man, who twenty-three months previous to his admission into the hospital had contracted a

simple chancre of the balano-preputial furrow. When admitted, the penis was a mere stump; from its base the ulceration proceeded in three directions, the first towards the raphe of the scrotum, the second upon the perineum, and the third to the inguinal fold. General condition of patient was bad, and he suffered acute pains. He was unsuccessfully treated, with the usual topical applications, and internally iron, quinine and chlorate of potassa. He was then put upon calomel, taking forty doses of one-quarter of a centigramme each per day, at intervals of fifteen minutes, by which he was salivated in five days. Fifteen days after this, the condition of the ulcer was improved. For ten days then the calomel was suspended and chlorate of potassa given internally, and astringent gargles used. Then, at the 25th day, the calomel was resumed. By the 35th day the improvement of the ulcer was very marked, and the calomel was again suspended, as salvation was induced again, and *Eau de challes* and chlorate of potassa substituted with astringent gargles. By the 30th day of treatment the ulcer had completely cicatrized. It had been treated locally with a solution of nitrate of silver.

The second case is that of a man sixty-five years of age, who had a phagedenic sore, which in spite of various energetic methods of treatment had steadily progressed for eight months and destroyed much tissue. He was ordered one centigramme of calomel every hour, which he took for six days, and was salivated. The remedy was then suspended for five days, resumed for fifteen days, left off again for ten days, and taken again for twelve days. The chancre was healed in sixty-eight days. As a local application the following formula was used :

R—	Tr. Opii,	.	.	.	.	.	.	.	.
	Tr. Aloes,	.	.	.	.	.	.	.	.
	Aq Rosae, aa,	.	.	.	.	.	.	.	℥ i.
M—	Ft. Lotio.	.	.	.	.	.	.	.	.

Iodide of potassium has also been found of service in the treatment of phagedena. Two cases are reported. The first is that of a man whose penis was nearly destroyed by a phagedena of eight months duration, which had been treated by the usual internal and external remedies. He was then ordered to take two drachms of iodide of potassium, which he did for sixteen days, when the chancre was nearly cicatrized. The dose was then reduced to one drachm a day, and the cure was effected in about six weeks, the patient having suffered from iodism during the time.

The second case is one of a chancre existing six months,

which had been attacked by phagedena, and as a result the glans was nearly destroyed and the urethra was perforated. All efforts to stop the destructive process had failed, so he was ordered to take iodide of potassium in doses of from one to three drachms a day; the latter dose was found necessary to produce the cure, which was obtained in about ten weeks.—*Annales de Dermatologie et de Syphiligraphie Deuxième Année, No. 3.*

On the Treatment of Syphilis.—Dr. J. K. Barton makes some very excellent remarks upon the treatment of syphilis. He considers that the object of treatment should not be the elimination of the syphilitic virus, but the disappearance of the symptoms; and when this is effected he thinks it is judicious to persevere in the use of the remedies for a few weeks only. Then, as regards the mode of administration of any of the mercurial salts, they should be gradually and gently introduced into the economy, rather than has been the practice, that they should be pushed to a point almost of saturation. He considers that the essentially chronic course of syphilis, and the gradual development and decline of its symptoms, and their tendency to relapse, warrant him in the opinion that an energetic and rapid medication only results in a deterioration of the health, and a more intractable condition of the present and future symptoms. The action of mercury is both rapid and energetic, and when employed in syphilis, over which disease it exerts so powerful an influence, it should be guardedly used. And this fact of the careless administration he considers to be at the root of the apparent discrepancies between the advocates of a mercurial and those of a non-mercurial course. Dr. B. thinks that an average of a large number of cases treated with and without mercury would present very little difference in the point of severity and duration of symptoms; therefore, a non-mercurial treatment is better than an ill-advised mercurial course. He thinks that salivation should never be produced; that apart from its not effecting a cure of the symptoms, being only a manifestation of mercurial poisoning, its effects on the system are baneful. In the early stages of syphilis Dr. B. prefers inunction to all other modes of treatment, and he thinks that the great advantages of this method consist in the gradual introduction of the mercury into the system, its gentle and curative action, and the avoidance of its energetic and poisonous effects. In the later stages of syphilis Dr. B. recommends a combination of iodide of potassium with the bichloride or the biniodide of mercury, in doses

of eight to twelve grains of the iodide to a twelfth or sixteenth of a grain of either of the mercurial salts mentioned. This combination fulfills the indication of the gradual introduction of the double salts into the system. Besides internal treatment, in cases where the cutaneous lesions are obstinate, local and general mercurial fumigation may be added with very great advantage. As results of this conservative mode of treatment, Dr. Barton details several cases which had been previously very carefully treated, and in which he obtained cures by milder, but more wisely directed efforts.—*Dublin Quarterly Journal of Medical Science, May, 1870.*

On the Use of Sarsaparilla in Syphilis.—Dr. T. Clifford Allbutt regrets that this drug has fallen into disuse in the treatment of syphilis. He thinks the reason of its failure in the hands of most practitioners, is the smallness of the dose given, which, instead of being three ounces a day, should be one or two pints. This treatment has been in practice at the Leeds Infirmary for at least a quarter of a century, and, particularly in the hands of the Senior Surgeon, Mr. Samuel Smith, has uniformly been followed by the best results. The preparation used is a decoction which only slightly differs from the compound decoction of sarsaparilla of the English Pharmacopœia; of this the patients take at divided doses from a pint to a pint and a half each day. Though the medicine is expensive, its rapidity of cure counterbalances that objection. The cases of syphilis in which this treatment is most beneficial are those in the tertiary period, in which obstinate ulceration is complicated by profound cachexia, or those in whom protracted courses of mercury have rendered their mucous membranes so irritable that they will not bear iodide of potassium, and are so debilitated as to seem only fit for the grave.—*Practitioner, May, 1870.*

On the Treatment of Syphilis.—Dr. Farquharson, of Rugby, expressed his surprise at the unsettled condition of the therapeutics of syphilis; having been himself an advocate of the anti-mercurial treatment, his failures had led him to use that agent. The worst cases of syphilis which he had seen, had been those in which either very little or no mercury had been given. When mercury is given, it is necessary to administer good food, for he has seen once two calomel vapor baths, and several times three, produce salivation in patients accidentally kept on a low diet; but when carefully administered, he considered mercury as a tonic. Mercury should be given early in

the disease, and though beneficial when used endermically, he prefers its careful internal administration. He thinks that mercury postpones and lightens constitutional symptoms, and that chlorate of potassa has no influence upon syphilis.—*British Medical Journal*, March 12th, 1870.

Puncture of the Tunica Albuginea in Blennorrhagic Orchitis.—M. Salleron calls in question the propriety of this procedure so unhesitatingly recommended by Vidal. His essay includes, besides a clinical history, a study of the physiological and pathological anatomy of the testis. In the healthy condition he thinks there is an accurate adjustment between the soft pulpy contents of the organ, and its tough, fibrous envelope, the tunica albuginea. Thus there is no tendency in an uninfamed condition of the testicle to the contraction of the tunica albuginea, even if a small incision is made through it, a clinical fact, which, though denied by Velpeau, is proved by an observation of the author. He relates the case of an officer, who, in a duel received an incised wound of the testis of from five to six millimètres, by which the seminiferous substance was distinctly seen, and yet it healed perfectly, without any hernia. He has observed the same phenomenon on two other occasions. From this clinical evidence, the author deduces the fact that the seminiferous substance is merely enclosed, and not at all compressed in the healthy testis. In the hyperæmic condition, which is always present in orchitis of blennorrhagic and other origin, this nicety of balance between the contained parts and the containing envelope is disturbed, and the tunica albuginea, rendered tense by internal pressure, has a continual tendency to retract, by virtue of the elastic tissue which has been demonstrated to exist in its outer layers ; and upon this fact of the disturbance of balance between the testicular tunic and its enclosed secreting structures, the retractable power of the tunic itself, he bases his objections to Vidal's operation. Referring to the assertion of Ricord that parenchymatous orchitis is only observed in two cases in a hundred, he thinks that that number should be doubled or tripled, and that in the generality of cases of acute orchitis, the epididymis and testis both participated in the inflammation, and that although there might be effusion of semen into the tunica vaginalis, it was not, as asserted by Rochoux, the result of an inflammation of that tunic, but rather a dropsy produced by venous compression at the head of the epididymis, which is the seat of intense inflammation. He admits, however, the existence of cases in which the inflammation was

solely confined to the epididymis, and thinks that the inflammatory processes always begin in that body, and secondarily involve the testis. This organ, during blennorrhagia, may be the seat merely of mild congestion, which produces little pain or uneasiness, or the congestion may be so active that a compressed condition amounting almost to strangulation of its contents is produced, which is always attended with very severe symptoms. As regards the termination of blennorrhagic orchitis in suppuration and gangrene, M. Salleron never has seen it, and thinks it is a myth, the belief in the possible occurrence of which renders the puncture of the testicle justifiable in the minds of its advocates. From what has preceded it will be seen that much doubt is attached to the statement of Vidal, that he had treated four hundred cases of this inflammation by means of an incision of the length of one and a half centimètres, and always followed by marked amelioration of the symptoms, and never by any disastrous consequences. M. Salleron thus treated two cases, and the result was that through the incision, the edge of which underwent ulceration by which the opening was enlarged, the glandular substance of the testis was extruded.

The first case was that of a soldier, who contracted blennorrhagia in February, 1846, and who was nearly cured at the end of five weeks. Then, in consequence of the resumption of his duties, his right testicle swelled and was very painful; this he attributed to a contusion, but of this he was not certain. Obligated to go to bed by the intensity of the symptoms, he was treated by baths, cataplasms, and bled by as many as sixty leeches, and he took Seidlitz water. This being futile, his testis was punctured as directed by Vidal, and from the incision a few drops of bloody serum, and from a wounded scrotal vein considerable blood, escaped. Pain and febrile movement immediately ceased, and the patient rested calmly. The next day the testicle was not much decreased in volume, and a slight hernia of its substance was observed. This condition continued until all of its contents were expelled, and at the twentieth day after the operation the wound had healed, but the testicle was a mere lump of fibrous tissue of the size of a filbert.

The second case was that of a man who three months after contracting clap, was affected with an acute orchitis of the left side. The testis was punctured and the acute symptoms immediately abated. Several days after the substance of the testis was expelled and he likewise had a mere nodule of fibrous tissue. It was also interesting to note that the loss of one testis was

followed by a uniform hypertrophy of the other. Having thus in two cases fairly tried this treatment, and in each case having obtained the same unfavorable results, and being strengthened in his opinion by the results of physiological and pathological study of the organ, M. Salleron tritely says, "that puncture of the tunica albuginea in blennorrhagic orchitis is not useful when not dangerous, and very dangerous when it would be useful." To reconcile the unsuccessfulness of his results with the marked success of those of Vidal, he thinks that many punctures made by the latter have been made in very slightly inflamed testes, or the punctures have been so very minute that there was no hernia, or that in these minute punctures, if there was a hernia it was so slight that upon the subsidence of the inflammation it was obliterated, or, again, that the puncture merely went through the tunica vaginalis, leaving the tunica albuginea intact; or still, that Vidal was attended by a providential luck, or that he operated in a manner which he fails to make known.—*Archives Générales de Médecine, February, 1870.*

Treatment of Orchitis by Antimonial Frictions.—This method of treatment was introduced in Strasbourg, by M. Michel, in 1865. M. Isaac owes to it great success. He makes minute punctures along the course of the cord as far as the scrotum, and then rubs in an antimonial ointment (pomade d'antimoine). These frictions are repeated until pustules appear; but it is necessary to avoid a coalescence of the pustules, as they cause troublesome cicatrices, and perhaps gangrene. In general, three or four frictions suffice, but they should be continued until well-marked amelioration is noticed. The same reasons which contraindicate the use of leeches upon the scrotum apply to this treatment. The after-dressing should be lint smeared with simple cerate. Under the influence of the eruption produced by the antimonial, which acts as a revulsive, the pains cease in forty-eight hours, the engorgement of the epididymis diminishes during the first ten days of treatment, and the cure is effected toward the end of twenty days, and there is no relapse.—*Lyon Medical, from Sud Médicale, 1870, 1 and 2.*

Acute Orchitis Treated by Puncture.—Mr. Nunn, at the Middlesex Hospital, followed the plan advocated by Mr. Henry Smith, of puncturing the testis in acute orchitis, regarding the operation as analogous to that of iridectomy in acute glaucoma. The patient, aged 19, had abscesses of the left testicle, which had burst, and on admission still discharged pus.

These abscesses had followed a gonorrhœa which began six weeks previously. By means of poultices and mercurial ointment locally, and cinchona and nitric acid internally, he was discharged convalescent in seventeen days. He was readmitted three days after for an acute orchitis of the opposite testicle, which was very severe, and limited more than is usually the case to the testis. Camphorated mercurial ointment was applied, with one-third of a grain of morphine internally, three times a day for four days, when, as there was no relief, the testis was punctured at three points. Resolution of the tumor and subsidence of the pain were the immediate results, and the patient was discharged cured on the twenty-fifth day of his second attack.—*Lancet*, January 29th, 1870.

Treatment of Acute Orchitis.—Mr. F. Fry reprobates the practice of puncture of the testis advocated by Mr. Henry Smith, and recommends a simple treatment which for thirty years has been successfully practised by him. It consists simply in the administration of one drachm of tincture of hyoscyamus four times a day, and a smart purgative (half an ounce of salts) every morning. The advantages of it are that patients can follow their occupations, and the cure is effected in a week or ten days.—*Lancet*, March 19th, 1870.

On the Treatment of Gonorrhœa.—Dr. D. C. Black regards antiphlogistic treatment as only beneficial in mitigating the more urgent symptoms, and powerless in preventing the formation of, or in neutralizing, specific pus. This end is only attained in his opinion by the abortive treatment, which he thinks really substitutes a simple inflammation for one of specific character. He thinks that as a result of the abortive treatment, the occurrence of ulceration of the urethra, perineal abscess and inflammations of the prostate and bladder are myths, and that the short and generally uncomplicated course of a simple artificial inflammation is infinitely to be preferred to the long and rebellious course of specific gonorrhœa. In accordance with other authorities, he considers this plan only suitable to the prodromic stage, and that when used after pus has been formed, the effects are surely to intensify the inflammation. Though he adheres to the specific character of the inflammation, he advises the use of diluents and antacids, and if necessary, narcotics. The use of Epsom salts is considered as positively aggravating in the acute stage, as the greater part of the salt passes away in the urine unchanged, and is very irritating after the urgent symptoms are passed; balsamics may be given internally, and a carefully regulated astringent injection should be used,

but not so strong as to irritate ; he considers the following as very beneficial ;

R—Zinci sulphatis,	. . . . .	gr. iiij.
Plumbi acet.,	. . . . .	gr. ij.
Glycerinæ,	. . . . .	ʒ i.
M—Aq. Rosarum,	. . . . .	ʒ j.

Half an ounce should be injected into the urethra every two or three hours, the use thus frequently is insisted upon. Dr. Black thinks it is by far better to throw in a number of syringe-fuls of injection, and to very thoroughly irrigate and cleanse the canal, than to retain the injection, which is more or less contaminated by the pus. The repeated and thorough irrigation of the canal is markedly beneficial in preventing a spread or perpetuation of the inflammation by retention of pus. The continuous use of one kind of injection, unless it is very effectual, is to be avoided, and repeated changes are of the utmost value. Solution of chloride of zinc, three grains to the ounce of rose water, sometimes works well, or the following :

R—Tannin,	. . . . .	ʒ j.
Sodæ Ciborat,	. . . . .	ʒ ss.
Glycerinæ,	. . . . .	ʒ j.
M—Aq. q. s. ad.,	. . . . .	ʒ viij.

The internal treatment combined with injections should usually cut the disease short in from ten to fourteen days. Attention is called to the fact that a simple serous discharge is kept up often by a prolonged use of injections after the specific inflammation has ceased. In cases of gleet not dependent upon stricture, the tincture of the perchloride of iron, in large doses of from forty to sixty minims, is considered by Dr. Black almost as a specific. Many very obstinate cases of gleet have also been cured by an injection of bichloride of mercury, of a strength of one or two grains to eight ounces of water, with a little glycerine or chlorate of potassa. Care should be used that although the injection is thrown back to the membranous portion of the urethra (and for the purpose Mr. Acton's syringe or its modifications are preferable), that it should not reach the bladder. The pain produced by the bichloride is more severe, but not as permanent as that produced by the nitrate of silver. Frequently one injection has sufficed to cure a discharge of long standing ; if one does not succeed it is advisable to wait a week or ten days before using the injection again, and perhaps use in the meantime a weak solution of tannin. Dr. B. has never known a case of gleet uncomplicated by stricture to resist this treatment.—*British Med. Journal, April 23d, 1870.*

Removal of an Encephaloid Sarcocoele by the Galvano-Cauteric.—Dr. A. Morpain reports a case of encephaloid sarcocoele removed by the galvano-cautery, desiring thereby to call the attention of surgeons to this expeditious and safe mode of operating.

The patient, a man 54 years of age, perceived, in August, 1868, that his right testicle was larger than the left, but it was not painful, and he thought the swelling was due to the pressure of tight pantaloons. He applied to M. Morpain, who ordered mild inunctions of iodide of lead ointment and a suspensory. In January, 1869, he was examined in consultation with M. Amussat. The testicle was then of the size of a hen's egg, but was not transparent, though there was fluctuation at the superior portion. An exploratory puncture furnished a quantity of serum. He was put upon an anti-syphilitic treatment, although he denied ever having had the disease. The result was a perceptible softening of the tumor, and he was allowed to go out, having the testicle suspended in a wad of cotton. He took internally iodized syrup of horseradish and pills of chloride of gold. In April there was a very perceptible increase of the volume of the organ, and it was nodulated. Another exploratory puncture was made with the same result as before, and the fact of cancerous degeneration was apparent. The patient was then examined by M. Nelaton, who, having satisfied himself that the cord was not involved in the disease, urged an operation. M. Ricord likewise concurred with this advice. The operation was performed by M. Amussat on the 4th of July, in the following manner: A platinum wire was introduced under the skin, in coincidence with the long axis of the tumor, each end of which wire protruded from the skin, and was connected with the clamp of *Grenet's* pile, and a section was immediately made, with the loss of a drop of blood. The incision extended from the extremity of the tumor to the inguinal fold. The tumor was then readily enucleated with the finger, and the cord was isolated and surrounded again by the wire, which was attached to the pile; it then was slowly cut. In the two applications only two teaspoonfuls of blood were lost. The wound was thoroughly healed by the middle of September, leaving a small linear cicatrix. The tumor measured longitudinally 13 centimètres, and transversely more than nine centimètres. The *tunica vaginalis* contained a sanguinolent fluid, the testicle was somewhat nodulated and traversed by numerous veins. The cord was healthy. The microscopic examination of the tumor was made by M. Robin, who pronounced it to be a specimen of the *encephaloid* variety.

The operation here performed was selected as being less liable to be followed by hemorrhage, erysipelas and pyæmia. Reference is made to the ablation of an enormous *fungous testis*, which was successfully done two years ago.—*Gazette des Hôpitaux*, Dec. 11th, 1869.

Treatment of Urethral Stricture.—Dr. F. J. Bumstead, after five years' practice of rupture and internal incision in urethral strictures, has arrived at the conclusion, contrary to his previous conviction, that they are perfectly safe and satisfactory methods of cure. As regards unfavorable symptoms after operations, beyond occasionally some slight urethral fever, he has met with no untoward symptoms. Besides the advantages of celerity of operation, saving of time, &c., he thinks that the immediate plan of treatment is attended with more permanent results. These operations are particularly indicated in strictures of the deep portions of the urethra. He thinks highly of the flexible filiform bougies provided with a metal cap, which can be screwed on the end of the instrument, and which serves as a conductor to the dilating bladder, and has so adapted this screw that it will fit upon any of the instruments, whether rupturing or incising, so that when the filiform bougie is in the urethra the surgeon may have his choice as to what instrument he will use. The idea is further extended by so adapting a slender catheter at its point that it can be screwed upon the bougie, by which it is conducted into the bladder, and by this means the surgeon can draw the urine from that viscus, when it otherwise might be impossible. Attention is called to the fact that surgical instrument makers very often make the screw tips so imperfect that they do not rightly fit. One advantage to a surgeon provided with these capped filiform bougies is that, as is well known, entrance is not gained at all times into the bladder; and, having succeeded in passing one of these bougies, it is only necessary to screw on an instrument and divide the stricture. As regards the length of time which should intervene after division of the stricture, Dr. Bumstead thinks that the third day is soon enough, and reprobates the practice of immediately after division introducing large instruments. As regards tying a catheter in the bladder after the operation, he never did it, nor has he seen the necessity for it. It is directed that after the operation the urine should be retained as long

as possible, and if, in passing it, a chill should be experienced, the patient should be put in a warm bath and quinine given in large doses. Rest for about twenty-four hours after is generally all that is necessary. At the end of three days a moderate sized sound should be passed, and followed by one the size of the urethra every third or fourth day. The practice of passing the sound should be taught the patient, and the necessity explained of its long-continuance at various intervals. As regards particular instruments, Dr. B. prefers for internal urethrotomy that of Maisonneuve. He has modified it by substituting for the long curve the short one of Sir Henry Thompson, and limiting the groove in the staff to its straight portion, as there is never necessity for incision deeper than the point to which that penetrates. As regards Voillemier's objection to the instrument, that it may wound healthy mucous membrane, he thinks that when properly made there is no such possibility. He uses Civiale's urethrotome only in moderate contractions of the straight, spongy portions of the urethra, and in cases where previous rupture has been insufficient. In rare cases of impassable stricture of the spongy portion of the urethra, he thinks that the lancetted catheter may sometimes be used, but he has never used it himself. In treating stricture by rupture he has used upon a number of patients Mr. Holt's instrument, which he has modified by having larger tubes made, by which the blades are separated more widely. This certainly was desirable, as many cases of stricture were merely stretched, not ruptured, by the original instrument. A further useful modification of this instrument was providing it with a screw tip, by which it could be attached to the filiform bougies. This screw tip is protected by a cap, by which it can be used without the bougie. It is necessary that the shaft should in all cases be pushed fairly through the stricture, as then the rupturing power is certainly gained, and that the tube be thrust down as *rapidly as possible*, and, before withdrawing the instrument, should be rotated so as to further separate the division. At the time when his article was written, Dr. B. had only used Voillemier's instrument in so few cases that he could not authoritatively speak of its merits. He thought, however, that as the dilating tube was provided with grooves in its side into which the two conducting blades could slide, and the whole form a round rather than oval shaft, it was superior to Mr. Holt's instrument, which, when the tube is thrust down, is oval. It is evident that the expansive force of the round instrument is greater in all parts of its circumference than the oval blade.—*American Practitioner*, January, 1870.

New Method of Treating Gonorrhoea by Injections.—Mr. Arthur E. Durham proposes a peculiar syringe with a view to making the treatment of gonorrhœa by injections easier, safer and more effectual. The instrument consists of a slender tube of vulcanite, terminated at one extremity by an elongated bulb ; at the point where the tube expands into the bulb, there is a ring of minute perforations, so directed that a stream thrown up the tube passes through them in a direction backwards and upwards. This tube is attached to an ordinary Davidson's syringe, and when well oiled should be passed into the urethra to a point beyond the inflammation ; the stream being then thrown in is prevented by the bulb from passing forwards, and by the direction of the openings it flows out, washing the urethra very thoroughly. The tube and bulb should measure about three and a half inches ; the tube should have the size of a No. 3 or 4 catheter, and the bulb that of No. 7, 8, or 9 catheter, having an olive shape, but no sharp shoulder. This syringe, Mr. Durham thinks, is applicable to all stages of gonorrhœa, even the acute, if then, it is possible to introduce the tube. He claims very promising results from its use.—*Guy's Hospital Reports*, Vol. xv., 1870.

On the Treatment of Chronic Urethral Discharges.—Dr. F. N. Otis, in a paper upon this subject, thus summarizes the pathological conditions which tend to perpetuate urethral discharges ; first, an enfeebled and enervated condition of that portion of the mucous membrane which has been the seat of inflammation ; second, the localization of the inflammation in the deeper portions of the urethra, or in folds of membrane, or in mucous crypts or follicles, which have escaped medication ; third, a granular condition following complete exfoliation of the epithelium ; and fourth, alterations in the course and calibre of the canal, due to changes produced by antecedent inflammation. Dr. Otis insists upon a careful diagnosis of the pathological condition which produces the discharge, and gives some suggestions for treatment.

FOR WANT OF RECUPERATIVE POWER OF THE MUCOUS MEMBRANE, the indications are to diminish the discharge and stimulate the membrane to a complete performance of its functions ; the stimulating solutions, he advises, are those of the salts of zinc, lead, iron and the vegetable astringents. He thinks that the character of the discharge should in every instance regulate the amount of stimulation required ; thus when it is of a purulent character, it should be decidedly stimulating, and

when simply of a mucous character, he advises astringent solutions, and in either case should there be pain, the addition of a few grains of extract of belladonna. He has seen decided benefit from injections of *phenol*, of a strength of from two to three grains to the ounce. As to the method of injection he advises that as the canal of the urethra should be compressed beyond the part which it is desired to medicate, as he has seen three patients who could, with a Davidson's syringe, throw water into their bladders, and in order that the injection should reach all parts, it should be *quickly* thrown in to prevent spasmodic action, and then retained three or four minutes.

LOCALIZATION OF THE INFLAMMATION in deep portions and folds of the urethra, render a modification of the ordinary syringes necessary; for this condition Dr. Otis has invented a syringe with straight tubes, of hard rubber, about six inches in length, and pierced on all sides of their distal two-thirds by very minute holes. These tubes are of various size, corresponding to Nos. 10, 12, 16 and 18 of the English scale, and by means of them the urethra can be fully dilated, and at the same moment bathed with a medicating solution to a depth of six inches. The inflammation in some cases is seated in the lacuna magna, for which Dr. Otis advises an injection of a drop of a strong solution of nitrate of silver, by means of a blunted hypodermic syringe. *Follicular sinuses*, opening somewhere upon or under the glans penis, are regarded by Dr. Otis as causes of chronic discharge, and should be treated by injection of a strong solution of nitrate of silver by means of the blunted hypodermic syringe; he details three cases thus treated. In some of these cases internal medication is also necessary. In preference to balsam copaiba and cubeba Dr. Otis uses ol. santalum citrinum in doses of from ten to twenty drops, and in an asthenic condition of the urethral mucous membrane has seen good results from muriate tincture of iron, with or without the addition of cantharides.

A GRANULAR CONDITION OF THE URETHRA may be suspected if the discharge resists the above plan of treatment. This condition may possibly be ascertained by the sensation of tenderness revealed by pressure, or the passage of a bulbous bougie, but as this is very often felt at the triangular ligament, at the commencement of the membranous portion, and at the neck of the bladder, it is therefore not sufficiently accurate. The most satisfactory method of treatment is by means of ocular inspection, and to this end Dr. Otis proposes hollow tubes of various lengths, made of hard rubber, having an entering

shaft to facilitate introduction, and an expanded, trumpet-shaped end, with a cleft in it to allow of the application of remedies. The pencil of light is thrown to the bottom of these tubes by an ordinary hand mirror, using either the sun's rays, or the light of a Tiemann's modified student's lamp, burning kerosene oil, in which ten grains of camphor are dissolved in each ounce. This tube, devised by Dr. Otis, and which he calls the *meatoscope*, has this advantage over Cruise and Desormeaux's endoscopes, from the fact that the black sides do not produce that troublesome play of reflection in its interior which is so objectionable in the metallic endoscopes, and, besides, by the india-rubber tubes, which are of various sizes, the eye of the examiner may be brought much nearer the object, and as they are graduated to half inches, it is easy to localize diseased spots. In the treatment of the granular condition of the urethra, the *meatoscope* is most useful, the tube should be passed down beyond the sensitive spot, which can be readily touched with a solution of nitrate of silver, 20 or 30 grains to the ounce of water, as the instrument is slowly withdrawn. Should sensitive spots remain after one application, they should be touched again, the applications being repeated in from four to eight days. For discharges from the prostatic urethra the syringe devised by Dr. J. Bigelow, of Brooklyn, answers an admirable purpose. Within the shaft of the instrument are two barrels, the one having an opening at the vesical end closed by a wire which runs through the tube, and at the distal end a small branched tube; the other barrel adjusts by its distal end to the syringe, while at its vesical or curved end it is perforated by minute openings. The external surface of this catheter-syringe is graduated to inches by which precision is gained in its use. When introduced into the bladder, the wire is slightly withdrawn, and a few drops of urine escape, from the small branch, which ceases when the wire is pulled forward again, then the instrument is withdrawn about half an inch, and the contents of the syringe thrown into the deep portions of the urethra.

DEVIATIONS IN THE COURSE AND CALIBRE, however slight, may be the cause of urethral discharges, and their recognition is of the utmost importance. Dr. Otis has devised a modification of the ball probe of Sir Charles Bell, and the acorn-shaped bougie of Le Roy d'Etiolles; it consists of a metallic olive-shaped bulb upon a flexible metal shaft; these, which are made of various sizes, from No. 7 to No. 20 of the English scale, and duly numbered, can be readily adapted to a handle

perforated throughout its length, which has a screw which will render the shaft firm. This should be bent to the curve of the ordinary sound, introduced slowly into the urethra as far as the bladder, and then slowly withdrawn, when, if any contractions are present, they will be readily recognized, and by means of the sliding handle an accurate measurement may be made of their depth, and then require the usual treatment of dilatation.—*New York Medical Journal*, June, 1870.

Treatment of Tinea.—Dr. Tilbury Fox, adverting to the inefficiency of the usual methods of treating ring-worm, makes some practical suggestions. He thinks that too much attention is directed to the destruction of the cryptogam, and no thought is bestowed upon the soil in which it finds its nidus; that fungi do not flourish upon healthy surfaces, but generally in persons of lymphatic temperament, who assimilate fatty substances deficiently. The indication then is plain, to so alter the soil that it ceases to yield pabulum to the parasite, and the indication is all the more imperative in cases where the fungus has reached deep portions of the derma, as at the bottom of a hair follicle; here both local and constitutional treatment is required to effect a cure. Then he advances the postulate, that besides an alteration of the soil and the death of the fungus, the consequences of the parasitic attack, such as baldness, eruptive tendency, folliculitis and œdema, caused by the combined irritation of the parasite and the parasiticide, applications should also be attended to. As regards general treatment, he recommends attention to the *prince vie*, then the administration of cod-liver oil, alkalies, bitter tonics, mineral acids, iron and arsenic, as the indications may suggest. In pallid, ill-nourished children, cod-liver oil is very beneficial, and if there are symptoms of slow or painful digestion, bitter tonics and mineral acids are indicated, while anæmia is remedied by iron; careful hygiene and fresh air are invaluable adjuvants. In cases of chronic ring-worm, where small scaly patches are seen scattered over the body, and in which there is evidently a want of nerve tone in the skin, the action of arsenic is very efficacious. Internal treatment is not very beneficial in tinea sycosis, unless there are evidences of strumous condition or chronic dyspepsia, and then it may be. He thinks, however, that where much induration exists there are sometimes good results produced by bichloride of mercury and bark or bromide of potassium, in conjunction with local measures. Local treatment is also to be carefully pursued. It is necessary to remove the hairs when the disease invades hairy parts of the body,

and the epilation should not be confined precisely to the patch, but should extend beyond its limits, as the disease in a progressive stage is sometimes unobserved, and by this procedure local applications may be brought in contact with it. In cases of *tinea circinata*, which rapidly increase, it is well to crop off the hair covering the whole of the vertex, and only leave a strip which will be seen when the hat is on. Crusting of favus and scaling of *tinea tonsurans* require poultices and oil, and then the surface may be bathed with a solution of hyposulphite of soda, ℥ ss. to ℥ vj. of water. In order to prevent the spread and dissemination of the disease, it is necessary to enforce the utmost cleanliness on the part of patients and nurses to remove scales loaded with the fungus, by repeated washing and oiling of the surface, and to epilate freely, as by these means much of the fungus is removed. The epilation should always be combined with parasiticide lotions, especially in favus. When the hairs are short and brittle in *tinea tonsurans*, they must be removed; if adherent, rub oil of cade well into the patch, or blister it; their removal is then facilitated. Epilation is to be continued as long as the microscope reveals the parasite, and until the normal appearance of the skin and hair is restored. In order that parasiticide applications may be effectual, they must be brought into direct contact with the fungus; in the different classes of *tinea* this is variously accomplished. In *tinea versicolor*, recent or old, and in *eczema marginatum*, lotions of the surface must first be carefully washed with yellow soap or diluted liquor potassæ, then all fatty matters are removed, and solution of hyposulphite of soda rapidly cures. *Tinea circinata* is rapidly cured by caustic applications of tincture of iodine, acetic acid, or iodine dissolved in oil of tar (℥ i. to ℥ i.); followed, when the scab falls, by applications of white precipitate ointment (gr. x to xxx to ℥ j.); this treatment has proved beneficial in obstinate cases of Burmese ring-worm. It is necessary to examine very frequently the hairs and scales with the microscope, to determine when parasiticide lotions may be suspended, otherwise we may injure the parts by repeated irritation. In that variety of *tinea tonsurans* called *tinea kerion*, in which the patch is boggy and the hair follicles distended with viscid secretion, epilation should be carefully performed. The loosening of the hairs in favus and *tinea tonsurans* is readily done by blistering with a solution of corrosive sublimate in alcohol (℥ ij. to ℥ vj.); this should not be repeated again for a few days, as it causes pain. Coster's paint (iodinii ℥ i. picis liq. ℥ i.), is likewise useful when the patches begin to resume their normal appearance, and the microscope does not reveal spores of the

parasite, it is necessary to diminish the strength of our applications ; in this condition a weak solution of the bichloride of mercury or an ointment composed of

R—Sulphuris,	. . . . .	3 ss.
Hyd precip. alb.,	. . . . .	gr. vj.
Creasoti,	. . . . .	gtt. ij.
M—Axungiaë,	. . . . .	3 i

is very useful. In tinea kerion, mild parasitoides answer a good purpose ; when patches of tinea decalvans increase rapidly it is well to apply Coster's paint about half an inch beyond their margins, and the enclosed patch should be stimulated to produce a new growth of hair. The following is an excellent stimulant :

R—Tr. Lyttæ,	. . . . .	3 vi.
Acet. dest.,	. . . . .	3 iss.
Glycerinæ,	. . . . .	3 ij
Tr Nucis Vom.	. . . . .	3 ss.
M—Aquæ Rosæ, ad.,	. . . . .	3 vi.

Eczema and pityriasis produced by the parasitic diseases require their usual treatment. It is essential in the use of any parasitoid treatment to employ friction sufficiently.—*Practitioner March, 1870.*

On the Constitutional Treatment of Skin Diseases.—Dr. McCall Anderson thinks that local diseases of the skin, which are not influenced by drugs generally, are acted upon by arsenic. Symmetrical and general eruptions indicate systemic origin, and the rapid appearance of eruptions without constitutional reaction, call for a cooling treatment and indicate avoidance of arsenic and iron. When a skin disease is complicated by derangement of the kidneys or digestive organs, the latter should first be attended to, as medicine directed against the skin disease would only aggravate it. Manifest improvement in an eruption indicates a continuance of the treatment, but in case patient wearies of a long continuance of a single prescription, it is well to change it. In cases where a particular medicine is objectionable to a patient, and which the physician feels convinced that it cannot be replaced by another with benefit, Dr. A. advises its prescription in a concealed form, thus if pil. opii is used, write for pil. saponis eo. instead ; a judicious regimen is absolutely essential for persons suffering with skin diseases, and without it a well directed treatment may prove abortive.

Sea air and sea bathing are not generally beneficial for skin diseases, except those of strumous origin.

Purgatives or *aperients* are useful, particularly in the early stages of a great many skin diseases, especially in the eczematous group; they are especially indicated when a digestive derangement or constipation are present; but are contra-indicated in debility, or where there is tendency to ulceration. A very excellent aperient is as follows:

R—Magnesiæ sulphatis,	. . . . .	℥ iij.
Acid. sulph. dil.,	. . . . .	℥ iss.
Ferri sulphat,	. . . . .	℥ iij.
Syr. simplicis,	. . . . .	℥ vj.
Syr. zingiberis,	. . . . .	℥ i.
M—Infus. quassiæ, q. s. ad.,	. . . . .	℥ xxiv.

Dose, one tablespoonful in considerable water three times a day.

The addition of wine of colchicum is indicated in gouty cases. In cases of nervous debility, especially when the bowels are easily moved, the following is an excellent formula:

R—Sodæ phosphatis,	. . . . .	℥ iij.
Acidi phosphor. dil.,	. . . . .	℥ ij.
Syr. zingiberis,	. . . . .	℥ vj.
Infus gentianæ co.,	. . . . .	℥ viij.
M—Aq. destill q s ad,	. . . . .	℥ xxiv.

A tablespoonful in a wineglass of water three times a day. Should this dose induce purging reduce it, if it is not efficient, and it is necessary to keep the bowels open, add to each dose of the first prescription a pinch of sulphate magnesia, or the same quantity of phosphate of soda to the second. In acute cases one or two full doses of calomel, followed by a seditif powder or castor oil, are of benefit at the onset, but continued purgation is injurious. Dr. A. thinks that sulphur is of little value, as its action is merely purgative, and from its generating sulphuretted hydrogen gas it is disagreeable, it is better to replace it by natural sulphur waters, which are more beneficial when drunk at the springs from their being fresh, and the fact that while there the patient is free from the anxieties of business.

Diuretics are useful in sluggish action of the kidneys, and in acute eczematous and erythematous diseases. Besides a diuretic effect, the alkalies are very beneficial by reason of their alkalinity, particularly in rheumatic or gouty cases, or those having acid dyspepsia, in whose urine there is a tendency

to the deposit of urates. The best alkaline diuretics are the acetate, citrate and bicarbonate of potassa; where a stimulant is required, carbonate of ammonia is to be preferred; arsenic and colchicum may be added when indicated. The following is a useful formula:

R̄—Ammon. carb.,	. . . . .	℥ i.
‘ Liq arsen. fowler,	. . . . .	℥ iiij.
Syr. zingiberis,	. . . . .	℥ vi.
M—Infus. cascarillæ, q. s. ad.,	. . . . .	℥ xxiv.

A tablespoonful in half a tumbler of water three times a day. Alkalies should always be very freely diluted and taken a short time before meals, as they interfere with digestion when taken after eating. It is necessary to persist in the use of the alkalies until the disease has disappeared, or until they disagree, and the dose should be regulated by the amount which produces alkalinity of the urine, which it is desirable to establish and maintain.

Sedatives and Narcotics may be necessary to induce sleep, but they do not relieve irritation of the skin. Sleeplessness during attacks of skin diseases may be due to debility, and they then require tonics. Opium is sometimes valuable in skin diseases, attended with considerable ulceration in broken down persons; but its benefit is due to its stimulant properties rather than an anodyne effect. In urticaria perstans, when not caused by constitutional vice, bromide of potassium is very beneficial, and the neuralgia which accompanies and follows zona, is relieved by morphine administered subcutaneously.

Cod Liver Oil is useful in strumous affections, more in warding off an attack than in curing one; its benefits are also marked in half-starved persons. Patients, who in consequence of privations, are ill nourished and become lousy, quickly lose their parasites upon the administration of cod-liver oil.

Arsenic, though it is the great cutaneous tonic, is not applicable to every case. Dr. A. formularizes his views upon this agent thus:

1. Judiciously administered, it is as safe as any other remedy, and can be used for months without detriment to the health.

2. It often requires a continuous use for weeks; in some cases the disease may resist its action for a considerable time, and then suddenly yield.

3. It should be given in larger doses proportionately to chil-

dren than to adults, and to infants may be given through the medium of the nurse's milk.

4. The dose should be at first small ; as a rule, should not be increased for some time, then it may gradually be increased until it disagrees, or the disease yields, then it should be gradually diminished.

5. It should not be given up altogether without good reason, but should be tried in smaller doses, or omitted for a few days until the bad symptoms have passed off, or used under a different form.

6. Puffiness of the face or irritation of the eyes are its physiological effects, and, if slight, should not cause us to suspend the agent ; sometimes its beneficial action is only observed when these symptoms are produced.

7. It is decidedly contra-indicated in acute cases ; and when its use is followed by marked increase of the irritation of the skin, the disease is probably not in a condition to be benefited by it.

8. It is usually more rapidly effectual when the disease, though chronic, is in a recent state ; and the first attacks yield more rapidly to it as a rule, than subsequent ones do.

9. It is contra-indicated in most of the cases which are complicated with digestive derangement.

10. It is apt to produce bronchial catarrh, so that it is necessary to warn patients of their liability to catch cold while taking it ; and for this reason it is contra-indicated in persons afflicted with bronchitis.

11. In exceptional cases it may prove beneficial in large doses ; in the case of a girl aged ten, having a very extensive eczema, commencing with two drops three times a day, it was increased one drop until the dose reached thirteen drops three times a day ; in seven weeks she took probably two and a half ounces of Fowler's solution, with the best of effects.

12. It should be given during meals or immediately after food is taken, and is better tolerated with a bitter infusion as a medium ; upon an empty stomach it often disturbs digestion.

13. It should not, as a rule, be discontinued entirely until some weeks after the disappearance of the eruption.

14. There are few chronic diseases of the skin of constitutional origin, syphilitic excepted, which are not benefited by it (often, however, other treatment is preferable) ; but it is especially valuable in psoriasis, pemphigus, lichen ruber, pityriasis rubra, and in many cases of eczema, unless contra-indicated as above. The most eligible preparations are Fowler's solution, of which the medium dose for children is two, for adults five,

minims, thrice daily, and Asiatic pills, of which the following is a modified formula :

R—Arsenici albi,	. . . . .	gr. ij.
Pulv. piperis nigræ,	. . . . .
Pulv. glycyrrhizæ,	. . . . .	a a., 3 ss.
Mucilag. q. s. Ft. pil.,	. . . . .	no. xxxij.

Dose, one pill three times a day.

Empyreumatic oils and their derivatives, particularly tar-water and tar pills, were much used formerly. Impressed with the powerful local influence of the tarry preparations over some diseases of the skin, Dr. Anderson determined to use them internally, using *pix mineralis*, but principally *pix liquida*, which latter disturbs the stomach less. The agents may be given in treacle or in capsules, never in pill form, as they become hard and useless. The dose is two or three minims, gradually increased to twenty-three daily. Commencing with small doses, the *primæ viæ* being in a perfect condition, the medicine agrees very well. This class of remedies is useful in cases of psoriasis of large extent, and in chronic eczema, especially if associated with chronic catarrh of the stomach or bowels, or with chronic bronchitis, which complications it often entirely removes.

Carbolic Acid is indicated in the same class of cases as the tarry preparations. Dr. A. has used it very extensively in doses of from three to ten grains a day, and prefers the following formula :

R—Acidi carbolici cryst.,	. . . . .	3 iij.
Glycerinæ,	. . . . .	3 i.
M—Aq. destill.,	. . . . .	3 v.

Dose, one teaspoonful in a large wineglass of water some time before taking food, thrice daily. Used with the same precautions as tar, it never disagrees, though a transient giddiness is sometimes complained of, particularly after the morning dose. It may be considered unsuccessful if no improvement is manifest in about two or three weeks after an increase of the dose has been tried. A slight aggravation of the eruption may be observed a few days after the commencement of the use of the drug, and is not an unfavorable symptom. Upon the whole, carbolic acid may be assigned a position next in importance to arsenic as a therapeutical agent. It may be considered particularly beneficial in psoriasis, for which disease any remedy in addition to arsenic may be looked upon as a boon. Dr. A. de-

tails some cases of psoriasis cured by this agent.—*Lancet*, February 9th, and May 14th, 1870.

Digitalis in Orchitis.—M. Besnier, of Hôpital Lariboisière, having seen digitalis successfully used by M. Debout, in hydrocele, has tried it with favorable results in orchitis. It is used as follows: the patient is placed on his back, and the scrotum elevated carefully, and continuously enveloped in compresses saturated in a concentrated infusion of digitalis leaves. The application may be either warm or cold, as pleasant to the patient, and should be covered by oil-silk.—*Bull. Gén. de Thérapeutique*, February, 1870.

Carbolic Acid in the Treatment of Psoriasis. Dr. John M'Nab regarding psoriasis as the local manifestation of a depraved condition of the system generally associated with the gouty diathesis, thinks that it requires local and constitutional treatment. As a local application he has used carbolic acid very successfully. He thinks that its *modus operandi* is by a coagulation of the albuminous secretion from the corium, which compresses the parts and thus prevents further exudation. He also thinks that the peculiar chemical composition of carbolic acid tends to neutralize the ill effects of the atmosphere upon the local processes. He recommends an ointment containing one part by weight of carbolic acid melted with four parts of lard. This is to be applied every night, and covered with gutta percha tissue to prevent evaporation. When the scales fall and the integument begins to resume its normal appearance, oxide of zinc ointment may be substituted. He thinks that the disease is more amenable to this local treatment, combined with an indicated constitutional course than to any other.

Dr. Liveing, of the Middlesex Hospital, concurs in the main with the opinions of Dr. M'Nab, and suggests that the acid should be used internally in those cases of psoriasis in which arsenic is either inadmissible, or in which it has proved unsuccessful.—*Lancet*, March 19th, and April 23d, 1870.

A Meat Diet as a Treatment of Psoriasis.—Dr. Passavant, in a letter to Professor Hebra, recommends as a specific remedy for psoriasis, the employment of an exclusively animal diet. Dr. Passavant's first experiment was upon himself, as he had suffered for twenty-five years from this disease affecting the entire surface. This led him to experiment with an exclusively animal diet, during which he improved and was well in a few weeks. Dr. P. has likewise seen another case treated

similarly, in which the scales disappeared in six weeks, and was followed by a relapse upon the resumption of ordinary diet. Dr. Caspari, speaking of this mode of cure, states he has not had the opportunity to try it, but that he is an example of the curative effects of a precisely different mode of treatment. He likewise has been a victim of general psoriasis, has tried every remedial agent, and some years ago, in consequence of a gastric trouble, he was unable to eat more than milk, bread, soup, rice, and porridge, under which diet he lost weight, and his physical powers were much reduced ; but his psoriasis disappeared. —*Practitioner*, March, 1870 ; *Deutsche Klinik*, Dec. 18, 1869.

Treatment of Psoriasis by Phosphorus.—Mr. Hardy having once used this drug in psoriasis, and discarded it, has again tried it upon five patients, three females and two males. One female took a teaspoonful of the following compound : oil, 150 grammes ; phosphorus, 10 centigrammes, and she was rubbed every night with a pomade of hog's lard, and phosphorus. She was benefited. The other two females were treated by frictions of a pomade of phosphorus, with obvious amendment. The men were treated by phosphorus internally and externally, and were benefited. —*Lancet*, Feb. 19th, 1870.

Copaiba in the Treatment of Psoriasis.—Dr. Simms, in a paper read before the Medical Society of London, advocated this drug as a remedy for obstinate cases of psoriasis, as well as in recent cases in young persons. The peculiar exanthem produced by copaiba, he thinks, occurs quickly in young persons, and more tardily, if at all, in elderly persons. —*Lancet*, April 23d, 1870.

Local Treatment of Eczema Rubrum.—Dr. J. K. Spender thinks that, in treating this disease, there are two main points which require attention : first, the application of a curative and soothing preparation ; second, that the latter should not be imperviously covered. Astringent powders and preparations of glycerine are usually inert. Ointments are hurtful. Black wash, combined with a tenth of its quantity of glycerine, is very efficacious. Its mode of application should be by strips of lint, saturated in the wash, and applied in an imbricated manner upon the diseased surface, the whole to be retained by a thin calico bandage, care being used not to cover with gutta-percha cloth, sheet india-rubber, or any impermeable fabric. Dr. S. thinks that although these impervious dressings preserve the moisture of the linen, the secretions become decomposed by this means, and the cure is retarded, and

it may cause a further extension of the inflammation. The dressings should be renewed twice a day, and before removal should be thoroughly soaked with water. Dr. S. has succeeded in curing many cases by this treatment, and to some few in which he has failed, he has applied a solution of nitrate of silver, which was then followed by the black wash.—*British Med. Journal, April 9th, 1870.*

Method of Curing Leprosy.—Dr. Bakewell communicates the method of curing leprosy of Dr. Beauperthiny, which heretofore has been kept a secret. Dr. Bakewell thinks that leprosy, though not curable, can be temporarily relieved, as all traces of the disease may be removed for a period of a few months to between two or three years. The treatment consists in the administration of Van Swieten's mercurial solution, each dose of which contains one-tenth of a grain of bichloride of mercury. But the chief means consist in the application of the oil of cashew-nut, which possesses powerfully irritant and epispastic qualities. Its action is slow, it tends to restore sensibility, promotes the absorption of the tubercles, and restores the skin to its natural aspect. Dr. Beauperthiny also used a solution of copper wire in nitric acid, reduced by an equal volume of water, or a liniment made by saturating an ounce of alcohol with iodine, and adding sixteen ounces of caustic soda of eight and ten degrees; or thirdly, balsam of copaiba with yolk of egg and rum. In all cases, frictions with cocoanut oil over the whole surface, are made night and morning. Diet is nutritious, excluding pork and salt fish, but wine is allowed. Dr. Bakewell thinks that all cases show signs of improvement.—*Lancet, April 16th, 1870.*

Lotion for Pityriasis.—Hardt gives, in the *Union Médicale*, the following formula: Nitric acid, one part; distilled water, one hundred parts, the mixture to be freely applied to the surface of the affected part. Instead of this, an oxygenated ointment may be applied with advantage, composed of thirty grammes of fat and one gramme of nitric acid.—*Practitioner, May, 1870.*

Treatment of Tinea Favosa by Alcoholic Fomentation.—Professor Cantoni has recently experimented on the effects of fomentations of rectified spirit in a case of tinea favosa, in which the crusts have been removed by the constant application of warm poultices. In this case a cure was effected at the close of the seventh week of the duration of the disease. It appears to be a plan worthy of further trial, both for its sim-

plicity and effectiveness. The alcohol, in penetrating the epidermis, acts as an energetic parasiticide, and accomplishes the destruction of the *achorion schonleinii*. It is important that the alcohol should be of sufficient strength.—*Journal de Médecine and Practitioner*, May, 1870.

Capsule de Raquim of Baume de Copaiba.—The samples submitted to inspection are of convenient form and size. They differ from ordinary gelatine capsules in that the envelope is composed of gluten, the great advantage of which is, that a larger quantity of copaiba may be enclosed. A further advantage of these capsules is that the balsam does not rise on the stomach. Being steeped for a time in some scented and fragrant liquid, the capsules emit a pleasant odor, almost free from the faintest smell of copaiba, although when broken open the odor of balsam is strong and characteristic.—*Lancet*, Dec. 18th, 1869.

Creeping Paralysis, of Syphilitic Origin, Cured by Anti-Syphilitic Treatment.—One more instance of the fruitful consequences of intelligent diagnosis is afforded by the record of a case treated by M. O. Bayer. The patient had suffered for about four years from constitutional syphilis, easily checked by appropriate treatment. The cure was commenced by inunctions of mercurial ointment, followed by large doses of iodide of potassium, which produced great effect. Faradisation of the affected muscles and subsequent tonics completed the cure. A syphilitic tumor of the scalp disappeared *pari passu* with the subsidence of the paralytic symptom.—*Union Médicale*, 75, 1869.

Carbolic Oil in Treatment of Scarlatina.—Dr. F. Smith, the author of the pamphlet on "Scarlet Fever and its Prevention," suggests, in a communication, the topical application of carbolic oil in scarlet fever. Reflecting upon the analogy in symptoms objective and subjective between scarlet fever and severe burns, though the origin of the exanthem he considers cryptomantic, he draws the conclusion that from the fact of the efficiency of carbolic oil in burns, it will likewise prove valuable in scarlet fever, particularly as oleaginous inunctions are known to materially mitigate some of the symptoms. He thinks that the mode of action is double, besides lubricating and relieving tension of parched surfaces, the antiseptic will destroy the scarlatina germ as it appears on the surface of the skin. No details of operation are given.—*Lancet*, Nov. 27th, 1869.

Editorial.

JOURNAL OF CUTANEOUS MEDICINE AND DISEASES OF THE SKIN.—This Journal, which for three years was edited by Mr. Erasmus Wilson, now reappears under the editorial supervision of Dr. Henry Samuel Purdon, of Belfast, a gentleman well qualified for the task by experience, and literary ability. The appointment to the Chair of Dermatology in the Royal College of Surgeons, forced Mr. Wilson to discontinue his Journal; he has, however, entrusted it to Dr. Purdon, to whom he promises his valuable aid. We notice among the corps of contributors the familiar names of men who were prominently identified with the Journal when under Mr. Wilson's care. The table of contents is varied, and the articles are noticeable for their practical character. A new feature is the Report on Dermatology in France by Dr. Doyon, the editor of the French Dermatological and Syphilographical Journal, which will be followed by reports from the editors of the other Dermatological Journals upon the state of Dermatology in their respective countries. The Journal is well printed, and we wish it the same success which its predecessor commanded.

ON THE PATHOLOGY OF ECZEMA.—In the article on the pathology of eczema, by Dr. Swift, in the last number of this Journal, it is stated that Hebra first published his views on the polymorphism of eczema in 1862; but that Dr. J. L. Milton lays claim to a priority in this particular. Milton states that his paper on this subject was published in May, 1861. In regard to the priority of Hebra or Milton in this matter, we have received the following communication from Dr. James C. White, of Boston. The letter may be perfectly correct so far as the statement goes that Hebra is entitled to priority in the publication of the views in dispute; but we have yet to learn that Dr. White is privileged, or in a position, scientifically, to speak of English Dermatologists as he does:

BOSTON, 10 PARK SQUARE, APRIL 17, 1870.

M. H. HENRY, M.D.:

Editor of American Journal of Syphilography and Dermatology:

Dear Sir:—When I read in Wilson's Journal Milton's claim to have first defined and published the views of the Vienna school with regard to the pathology

of eczema, I looked upon it as an ordinary manifestation of English conceit in such matters, hardly worth noticing; but now that Dr. Swift, in his article on eczema in the last number of your Journal, brings this claim to priority again to the notice of the profession, I desire to make the following statement:

Milton says: "Hebra only published his views on the subject in December, 1862," and that his own paper on the subject was read in 1860, "*or nearly a year and a half prior to the appearance of Hebra's first communication on the subject.*"

While I was in Vienna in 1856 and 1857, Professor Hebra was teaching these same doctrines concerning the pathology of eczema; as my note-book shows, they were not new views of his own at that time, and I do not know when he did not hold and teach them. If Dr. Milton will consult the number of the *Allgemeine Wiener Medizinische Zeitung* for February 8th, 1859, he will find them published at length; the same as I heard them from Hebra in 1856, the same as may be found stated in full in the second Lieferung of his great work.

I am very truly yours,

JAMES C. WHITE, M.D.,

Adjunct Professor, and Lecturer on Skin Diseases in Harvard University.

THE NEW YORK DERMATOLOGICAL SOCIETY.—At the first anniversary meeting of the New York Dermatological Society, held June 14th, the following officers were elected to serve for the ensuing year: President, Dr. Henry D. Buckley; Vice-president, Dr. William H. Draper; Recording Secretary, Dr. F. P. Foster; Corresponding Secretary, Dr. F. Zinsser; Treasurer, Dr. R. W. Taylor; Librarian, Dr. Satterlee. The following gentlemen were elected honorary members: Prof. W. Boeck, of Christiania; Profs. Hebra and Zeissl, of Vienna; Prof. Hardy, of Paris, and Mr. Jonathan Hutchinson, of London.

Bibliography.

LEÇONS SUR LA PHYSIOLOGIE COMPARÉE DE LA RESPIRATION : par Paul Bert, professeur de physiologie à la Faculté des sciences, J. B. Baillière Paris, 1870 : 1 vol. in-8 de 500 pages avec 150 fig.

PROGRAMME DU COURS D'HISTOLOGIE. Professe, à la Faculté de médecine de Paris, par Ch. Robin, professeur d'histologie à la Faculté de médecine de Paris, membre de l'Institut (Académie des sciences) et de l'Académie de médecine. Seconde édition, revu et développée. J. B. Baillière. Paris : 1870, 1 vol

Traité Médecine opératoire, Bandages et appareils par Ch. Sedillot et L. Legouest, Quatrième Edition avec figures intercales dans le texte. 2 vols. Paris : J. B. Baillière. 1870.

MODERN THERAPEUTICS: A compendium of recent formulæ and Specific Therapeutical directions. By George H. Napheys, A.M., M.D. Philadelphia : S. W. Butler, M.D. 1870.

THE PREVENTIVE OBSTACLE: or Conjugal Onanism. By L. F. E. Bergeret, Physician-in-Chief of the Arbois Hospital, (Jura.) Translated from the third French edition, by P. De Marmon. New York : Turner & Mignard. 1870.

PERIODICALS RECEIVED.

Annales de Dermatologie et de Syphiligraphie. Deuxième année. No III Paris : 1870 Archiv für Dermatologie und Syphilis. Jahrgang, 1860. Zweites Heft Prag. Edinburgh Medical Journal. March to May, 1870. Journal of Cutaneous Medicine and Diseases of the Skin. June. Vol. IV, No. 13. London : 1870. The Practitioner. No. XXII. 1870. May, 1 The New York Medical Journal. April to June. The Journal of Psychological Medicine. April. American Journal of Insanity. April The American Practitioner. April to June. The American Journal of the Medical Sciences. April, 1870. California Medical Gazette. April to June Buffalo Medical and Surgical Journal The Journal of the Gynæcological Society of Boston. The Medical and Surgical Reporter, Philadelphia. The Medical Record, New York. The Medical Gazette, New York. The Chicago Medical Times. The Medical News and Library, Philadelphia. The Boston Medical and Surgical Reporter. The Pharmacist, Chicago. The Chicago Medical Examiner. Good Health—a Journal of Physical and Mental Culture. Boston. April to June.

Foreign books for review may be addressed to the following agents of the publisher, who will forward them immediately :

LONDON.—Messrs. Williams & Norgate, 14 Henrietta-street, Covent Garden, W C.

PARIS.—Mr. Cs. Reinwald, 15 Rue des Sts., Pères.

LEIPZIG.—Mr. L. A. Kittler.

American books and papers for Review may be sent directly to the Editor, or to care of F. W. Christern, the publisher, No. 77 University Place, New York.

THE AMERICAN JOURNAL
OF
SYPHILOGRAPHY AND DERMATOLOGY.

OCTOBER, 1870.

Original Communications.

ON GONORRHOËAL AFFECTIONS OF THE PROSTATE.

BY ERSKINE MASON, M. D.,

Surgeon to the Charity Hospital, etc.

THAT the prostate is at times the seat of inflammation, as a result of gonorrhœa, all must admit ; but that it not unfrequently results as a consequence of neglected or improperly-treated blenorrhagia, appears to be often forgotten by those who frequently prescribe for the relief of this disease.

It will be the object, in this brief paper, to picture as concisely as possible the causes, symptoms, and results, as well as the treatment requisite in affections of the prostate due to gonorrhœa. First, we should bear in mind the relations which this body holds to the urethra, as well as the structure of the organ and its physiological functions. We now are no longer to regard this organ as a gland, but rather as a muscular body, it being in structure two-thirds muscular tissue and one-third glandular. Its shape is well likened to that of the Spanish chestnut, and, in health, it possesses but *two lobes*, which are joined together by an isthmus of the same material as that which constitutes them. It surrounds the neck of the bladder, and through its upper portion passes the first part of the urethra. Resting on the

rectum, and separated only from the bowel by the recto-vesical layer of the pelvic fascia and some areolar tissue, it is inclosed by a fascia of its own, and held in position by the pubo-prostatic ligaments, the apex being towards the pubis, from which it is distant but half an inch. Its ducts, which are numerous, all open into the first portion of the urethra, and the weight of the body in health is about five drams. The measurements of the normal prostate should always be borne in mind, and these are found to be, transversely, at its base, one and a half inches, and, antero-posteriorly about three-quarters of an inch. The facility with which this body can be examined and pathological changes noted, may be increased by having the patient empty his bladder, before we make an examination, for, if the bladder is distended, it may be confounded with the posterior border of the prostate.

Inflammation is more prone to attack this body about the close of the second week of gonorrhœa, and is of greater frequency in young subjects. I have observed it most frequently at about twenty-five or thirty years, and in those who were addicted to the use of stimulants, or led a luxurious mode of life. The cause of this affection is due, no doubt, to the inflammation passing down the urethra till it reaches the prostatic portion, and thence through the ducts of this organ, the mucous membrane of these ducts being but a continuation of that which lines the urethra. Another ground for this view is, that at the same period we are more apt to have epididymitis setting in, and, in that disease, we know the inflammation propagates itself through the vas deferens. This disease, therefore, must not be looked upon as the result of sympathy or metastasis.

Prostatitis will be found to follow exposure to cold, mechanical injuries, stricture, strong irritating injections, especially when used during the acute stage of gonorrhœa, as well as the indulgence in alcoholic stimulants at this time, and some, also, believe it to arise from large doses of either copaiba or cubebs. The most frequent cause, however, we believe to be due to the extension of gonorrhœal inflammation.

The invasion of this disease may be either sudden and unexpected, or a feeling of general indisposition may precede its

appearance. Whatever the mode of attack, the early symptoms are those of pain, a feeling of weight at the neck of the bladder, a burning sensation, soon followed by desire to void urine, which is almost impossible for the sufferer to control. The pain, which at first may be slight and of the dull aching variety, soon becomes very sharp and burning. The sense of weight in the perineum is greatly increased, and the pain extends along the spermatic cord into the groin and even passes up into the lumbar region. Walking, or any jarring sensation, and even standing erect will often aggravate the suffering. His rectum also will very likely be implicated, giving rise to painful defecation, owing to the feces passing over the inflamed prostate, which by digital examination will now be felt as a hot and swollen body projecting into the bowel. Difficulty in voiding urine will also increase, and reach such a degree that the patient may suffer from retention. His water becomes aerid and high-colored, and when the attack is severe may be tinged with blood. Should the attack run on towards suppuration, or terminate therein, the character of the perineal pain becomes deep and throbbing; and the constitutional symptoms also assume a more grave character. The face becomes flushed, pulse hard and quick, and tongue furred, with increased restlessness, and he complains of great tenesmus, due to the enlarged prostate filling up the rectum. Perhaps also he may have a seminal emission at night which, if mixed with a few drops of blood, tends greatly to alarm him.

The duration of the acute affection before it terminates in suppuration may be six or eight days, or else after this time it may subside into chronic prostatitis, having escaped suppuration. If the termination be that of resolution, the symptoms will subside in two or three days. Should suppuration take place, we then have abscess of the prostate, and we may have either a single abscess, or numerous small ones, in one or both lobes. Indeed in some cases the whole organ has been infiltrated with pus. Lallemand speaks of a young man in whom the urethra was perforated like a sieve, through which pus flowed into the canal. The abscess may open into the bladder or urethra, and has often done so at the time of introducing a catheter, and

urine been infiltrated into the substance of the organ, thus tending to perpetuate the trouble. They again open into the rectum, perineum, or adjacent cellular tissue, thus giving rise to fistula in various directions.

The diagnosis at first is not always easy, for we may confound it with acute cystitis, still with a study of their respective symptoms error will be avoided. In both we have pain in the perineum and trouble with micturition, but in prostatitis the perineal pain is deep seated and of the burning, throbbing variety, and the sense of weight is greater. At first, in cystitis, the constitutional disturbance is not so great as a rule. We have vesical tenesmus in cystitis, but there is no obstacle to the passage of water, and, on passage of the same, the burning sensation as it passes over the prostate is not complained of. Again the urine cannot be retained so long in cystitis. The rectum is not involved, as in prostatic trouble. No impediment is offered to the introduction of a catheter, except momentary if at all, in cystitis; while in prostatitis we may find no little difficulty in the use of a catheter. The finger in the rectum in prostatitis reveals the gland enlarged, and exquisitely tender, and hot to the touch. In cystitis no such tumor exists. Bearing these distinctions in mind we shall not be likely to commit an error in diagnosis. Cystitis, it is true, is often associated with this disease, and is certain to be to a greater or less extent, unless the trouble tends rapidly to resolution.

Prognosis.—When the case is seen early, and properly treated, the prognosis is good, but for this result the patient must be under the complete control of his physician. Should the case be neglected on the part of either physician or patient, the result will be very disastrous. We have lately had the privilege of examining a specimen from a patient at the Colored Home, where, as the result of a neglected prostatitis, but little was left of the body, save its capsule, so completely had it been disorganized from suppuration. Fistulous tracts communicated with the rectum and urethra, and one passed between the peritoneum and pelvic fascia, which, allowing the escape of pus in this direction, had given rise to some cellulitis. It is needless to say that death in this case was the result of prostatitis.

Treatment.—As soon as any symptoms of this trouble show themselves, our treatment must be prompt and energetic, in order that the case shall terminate in resolution.

If we are using injections for the relief of a gonorrhœa, these must be stopped, as well as all mixtures which contain cubeba or copaiba. Should it be deemed proper to use a diuretic, the mildest should be employed, as spts. etheris nit., or simple flaxseed tea. The patient must at once take to his bed, and be kept in the recumbent position till all symptoms have entirely disappeared. Six to twelve leeches should now be applied to the perineum, and, after they have fallen off, the parts should be well covered with a large flaxseed poultice. A saline cathartic will also be of great service at this period of the disease in relieving the congested state of the vessels. Should the symptoms not abate in a few hours, we should again resort to the leeches. Warm fomentations, or poultices to the perineum, we have found to act far better than the use of the hip-bath, which often is not readily obtained, without considerable annoyance and discomfort to the patient. For the relief of pain and the sensation of weight in the rectum, anodyne injections and opiate suppositories are highly spoken of. The great pain often experienced by the introduction of the nozzle of the syringe into the bowel militates against this practice. The same may be said, though not to such a degree, in regard to suppositories. In two of our cases, the presence of a suppository could not be tolerated. In another case of prostatitis, though not of a gonorrhœal nature, we saw a belladonna suppository of 2 grains produce many of the symptoms of belladonna poisoning, together with the inability to pass water without the use of the catheter. We therefore, in preference to the anodyne enema or suppository, prefer the use of subcutaneous injections of morphia, which in our hands have answered every purpose, without the objections attendant upon enemas or suppositories. For the constitutional symptoms we can speak highly of the tincture of aconite root, together with large doses of liq. ammon. acet., and diluent drinks. Should the patient be unable to pass water, the use of the catheter will be called for. This operation, *especially* at this time, will require the greatest deli-

cacy on the part of the physician. Should we detect any point of fluctuation, or pointing, wherever it may be, our duty is to resort to the bistoury and evacuate the pus. This is readily accomplished when the abscess points either into the rectum, or perineal region—when opened into the bowel, the rectum should be kept quiet for a few days by means of opium. Should the abscess project toward the urethra—and this is not always easy to determine—the walls of the abscess may be ruptured by the point of the catheter, and its contents discharged into the urethra. This mode is often successful. Then we must resort to the catheter to empty the bladder for a few days in order to prevent the urine from entering the abscess and giving rise to very serious trouble. In conclusion, all our endeavors must be directed towards bringing about resolution, and, if we fail in the attempt, to give an exit to pus as soon as discovered, in order to prevent its diffusing itself through all the perineal tissues and giving rise to numerous sinuses, or perhaps opening into the cavity of the peritoneum, and death being the result.

We now come to speak of what is at times a result of the acute form, namely *chronic prostatitis*. This affection which was first, we believe, called to the attention of the profession by Dr. Gross, under the name of prostatorrhœa, is said to be due chiefly to masturbation, and ungratified venereal desires, as well as to affections of the rectum; we have seen it follow what we have no doubt was a cure of acute gonorrhœal prostatitis. We have met it also in patients who have suffered from frequent attacks of gonorrhœa at short intervals. One case we well remember occurring in a gentleman 30 years of age, who had been under treatment for some time by different physicians for what is called “irritable bladder.”

His complaining of a sense of fulness and weight about the rectum, together with other symptoms, led me to make a digital examination of the prostate, when that body was found considerably enlarged, somewhat painful and projecting into the bowel. Indeed, it felt more like an india-rubber ball, than any thing else to which I could liken it. This affection must not be confounded with the hypertrophied body we meet with in advanced life, it being a disease peculiar to young men,

and one amenable to treatment. The symptoms, indeed, are in the main very similar to those cases of pure prostatorrhœa, or spermatorrhœa, which yield such abundant harvests to charlatans. We find the same discharge of a mucous stringy character, which at times is increased by hardened fæces passing over the prostate, or again, the discharge appears more of the character of a gleet than any thing else. Together with these symptoms we may have frequent nocturnal emissions of semen.

The calls to void urine are more frequent, and considerable straining may be required to completely empty the bladder, and a smarting sensation perhaps is complained of at this time in the deeper portions of the urethra. The water, towards the close of micturition, may dribble away; and, if asked, the patient may state that his water is not expelled with the usual force. Uneasy sensations in the region of the groin, weight and pain in the perineum, together with, at times, irritability about the anus and painful defecation, form the usual catalogue of the local symptoms. We also find his mind greatly disturbed with regard to his condition; he is low spirited, suffers from dyspepsia, languor, and headache—in fine may be a complete hypochondriac. A physical examination reveals pain upon the introduction of a sound, especially just as it enters the bladder. Some obstruction also may be encountered at this point. Per rectum the gland is discovered tender and enlarged. Indeed it may be quite hard to the touch. But if so we must not confound it with the hypertrophy that we frequently find towards advanced life; nor is this affection known to result in that condition. The *prognosis* usually is good. As to *treatment*, the first duty of the physician is to quiet the patient and endeavor to convince him that he is needlessly alarmed. This he can do most readily by assuring him that this discharge from the urethra is not semen. His nervous system, which is greatly at fault, must be seen to at once. Tonics, nourishing and easily digestible food are to be used, and the bowels regulated by saline cathartics; where there is much tenderness in the perineum, a few leeches applied at the interval of a week will be of service. Counter-irritation by blister is advised by some,

together with a course of the iodide of potassium. When there is considerable swelling of the prostate, the occasional application of a few leeches to the perineum, together with the use of the iodide of potassium, has appeared to us to have been of great service in restoring the body to its normal dimensions.

ON VACCINO-SYPHILITIC INOCULATION.¹

BY FRANK P. FOSTER, M. D.,

House Physician to the New York Dispensary.

IN the last number of the JOURNAL a few of the less important of the recorded cases in which syphilis was reputed to have been conveyed by vaccination were given, with such comment as seemed desirable for the sake of continuity. Of the cases which remain to be considered, so many are, in one respect or another, defective, that it will be necessary to relate them with some brevity, that we may have sufficient space to devote to the consideration of the few important ones.

X. TASSANI'S CASES.²—These cases occurred at Grumello, in the Province of Cremona, in 1841, and were reported by Tassani, who was deputed to investigate the facts the following year. Dr. Bellani, a public vaccinator, had sent a child to Befutrafio to be vaccinated, in order that he might serve as vaccinifer for the district. This child is described as healthy, but its father had had chancre the year before. In a year after its vaccination the child was attacked with pustules on the face and arms, each surrounded with a red ring, and with acuminated, red, dry papules. It afterwards died of dysentery.

From this child's arm sixty-four children were vaccinated. Some of them developed indurated sores at the vaccinal punctures, after the vaccinal crusts had fallen off, and afterwards, general syphilis, which was communicated to mothers and nurses. Eight children and two women died. All the others recovered.

XI. CECALDI'S CASES.³—Two sisters, æt. two and eleven years respectively, and a child, æt. twenty-two months, of another family, were vaccinated from "a fine, healthy child." Regular vaccinia followed, and, in about

¹ Continued from page 204.

² *Gazzetta Medica di Milano*, Oct. 14, 1843, Quoted by Auspitz, *op. cit.*, and Viennois, *De la Transmission de la Syphilis par la Vaccination*, *Arch. Gén. de Méd.*, June, 1860, *et seq.*, republished in a volume, entitled *De la Syphilis Vaccinale*, comprising communications to the French Academy by MM. Depaul, Ricord, Biot, Jules Guérin, Trousseau, etc., Paris, 1865.

³ *Revue Méd.-Chir.*, Vol. XIII., 1853.

thirty-five days, syphilitic manifestations about the anus and genitals, etc. No mention is made of an initial lesion.

XII. BONNIÈRE'S CASE.¹—This case was related at the recent "Vaccinal Congress" at Paris. M. Bonnière vaccinated a syphilitic child, and then threw away the needle which he had used in the operation. Afterwards another physician chanced to employ the same needle in vaccinating two adults, who soon afterwards showed signs of syphilis.

XIII. VIANI'S CASES.²—A syphilitic child had infected its mother and four nurses by the breast, but, having ceased to show any signs of disease, other than ophthalmia, was vaccinated, and furnished virns for the re-vaccination of its uncle and aunt, both of whom developed syphilitic initial lesion after the desiccation of the vaccinal efflorescence, and subsequently general syphilis.

XIV. DRYSDALE'S CASE.³—A female child, said to have been born healthy, and of healthy parents, was vaccinated at the age of nine weeks. Four weeks afterwards an eruption appeared, accompanied by other manifestations, all of which were looked upon as syphilitic. Dr. Drysdale and Mr. Dunn found the vaccinal scars copper-colored, with distinct induration. The case was said to have proved fatal. Vaccinifer not described.

XV. CASES AT LYONS.⁴—Two newly enrolled soldiers were vaccinated at the military hospital. The pustules, after some time, became transformed into chancres, which were followed by secondary symptoms, especially ecthymatous pustules on the limbs.

XVI. GALLIGO'S CASES.⁵—In 1857, at Rufina, near Florence, several children contracted syphilis by vaccination from a child of syphilitic parentage. The blood of the vaccinifer is stated to have become mixed with the vaccine lymph.

XVII. LECOQ'S CASES.⁶—In 1850, several soldiers of a French regiment were vaccinated from the arm of a comrade who had had chancre three months previously. Two of them, the last of the series, afterwards suffered from general syphilis, preceded by alleged initial lesion at the vaccinal punctures. Lecoq subsequently stated, in a letter to Viennois, that he remembered that blood had been drawn in the operation.

¹ *Lancet*, June 18, 1870.

² *Gazetta Medica Lombardia*, 1849; *Gaz. Méd. de Paris*, 1849.

³ *Brit. Med. Jour.*, April 25, 1868.

⁴ *Lyon Médicale*, quoted in *Brit. Med. Jour.*, February 19, 1870.

⁵ *Gaz. Hebd.*, 1860, p. 519; and *Gaz. des Hôp.*, 1862, p. 139.

⁶ Guyenot, *De l'Inoculation de la Syphilis Constitutionnelle*; Thèse. Paris, 1859, quoted by Viennois, *Arch. Gén. de Méd.*, 1860, p. 33.

XVIII. ALIÈS' CASES.¹—These occurred in 1843, in the department of the Haute-Saône, in France, and were likened to the Rivalta epidemic.

XIX. HOUGHTON'S CASE.²—A girl aged nine years was brought to Mr. Houghton, at the dispensary at Dudley, with secondary syphilis, which had appeared "almost immediately after vaccination." The vaccinifer is not described, and there is no account of an initial lesion.

XX. MORAX'S CASE.³—A child, twenty-six months old, whose mother had always been free from venereal disease, and had previously given birth to three healthy children, whose father had had chancres and buboes in his youth, was vaccinated on the 28th of May, 1863, at the *Mairie de Bati-gnolles*, the vaccinifer being, according to the mother's account, a very ill-conditioned child. Six punctures were made, and gave rise to six well-developed vesicles, which suppurated for six weeks. A small tumor then appeared on the right cheek, and at the end of July an eruption, considered to be syphilitic roseola, suddenly appeared over the body, after a bath. Early in September large red tubercles appeared on the genitals, and about the anus, and furnished a fœtid secretion. On the 10th of September there were squamous eruptions extensively scattered over the body; slight ulceration of the upper lip; an enlarged gland under the angle of the jaw, on the right side, with similar swellings in each axilla; vaccinal cicatrices large, forming coppery-red patches, covered with epithelial *débris*; mucous patches about the anus and in the groins, with copious secretion. The child's general condition was good. Mercurial treatment had nearly caused the manifestations to disappear, when an attack of diphtheria carried the patient off.

XXI. LAROYENNE'S CASE.⁴—A child, fifteen months old, was vaccinated at Paris, four punctures being made in each arm. Three of the pustules on the right arm increased in size, and persisted to about the seventieth day after the operation, at which time pustules appeared on the scalp and on the vulva. The child and its mother entered the Saint Antoine Hospital, and during their stay there a tubercle appeared on the mother's left nipple, ulcerated, and was accompanied with axillary adenitis, and constitutional symptoms. At this period Dr. Laroyenne observed the initial lesion and syphilitic roseola on the mother. The child presented only discolored

¹ *Revue Médicale*, Jan. 15, 1865, p. 29, quoted by Bousquet (*De la Syphilis Vaccinale*, p. 182), who says, "I must confess that our distinguished *confrère's* meagre account does not present sufficient reasons for deciding that the sort of syphilitic epidemic observed by him really originated in the vaccination."

² *Brit. Med. Jour.*, March 3, 1866.

³ Bouvier, *De la Syph. Vac.*, p. 172.

⁴ *Gaz. Méd. de Lyon*, June 16, 1864, p. 293, quoted by Bouvier, *De la Syph. Vac.*, p. 174.

spots consequent on antecedent lesions. Both recovered under mercurial treatment. The father had always been healthy.

XXII. CHASSAIGNAC'S CASE.¹—A healthy infant was vaccinated at the *Mairie de Montmartre*. The vesicles were regular, and cicatrization was complete on the fifteenth day. Some days afterwards there were two ulcers on the right arm, and one on the left, at the seat of vaccination. Two months after the vaccination the ulcers were as large as a fifty-centime piece, with indurated bases, engorged ganglia, and subsequently general syphilis.

XXIII. HÉRARD'S CASE.²—A perfectly healthy infant was vaccinated at the same *Mairie*, on the same day as in Chassaignac's case. Three weeks afterwards, the vaccinia having proceeded to cicatrization, one cicatrix on each arm became transformed into an indurated prominence; there was concomitant cachexia, and subsequently general symptoms which were regarded as undoubtedly syphilitic.

XXIV. RODET'S CASE.³—A child a month old, who, on the 15th day after birth, first showed syphilitic manifestations, furnished lymph for the vaccination of another child, on whose right arm a pustule ulcerated and continued open for a long time. Four months afterwards M. Rodet found this latter child suffering from well-marked syphilis, and observed on the arm a cicatrix as large as a 50-centime piece, with induration. The mother was perfectly healthy.

XXV. BERGERON'S CASE.⁴—M. Bergeron vaccinated a child, apparently healthy, in whom, after regular vaccinia, chancreous-looking ulcers occurred under the crusts, resting upon elastic, indurated bases, with engorgement of the corresponding ganglia. Looking upon the ulcers as true chancres, he yet called M. Cullerier in consultation, and they both were unable to determine at first the nature of the lesion. Simple tentative treatment, however, was followed by rapid cicatrization, and frequent examination subsequently failed to detect any syphilitic manifestation.

XXVI. AUZIAS-TURENNE'S CASES.⁵—These comprise four sets of cases, viz. :—

1. In 1852, M. Auzias discovered in three children, who had been vaccinated at the Academy of Medicine a month or two previously, chancres at the points of insertion, engorgement of the axillary ganglia, and syphilitic roseola.

¹ Depaul, *De la Syphilis Vaccinale*, p. 111.

² *Ibid*, p. 110.

³ *Gaz. Méd. de Lyon*, January 16, 1865, p. 35, quoted by Depaul and Bouvier, *De la Syph. Vac.*, pp. 107 & 170.

⁴ Blot, *De la Syphilis Vaccinale*, p. 47.

⁵ *Correspondance Syphilographique*, 1860, p. 34 (quoted by Bouvier, *loc. cit.*), *Courrier Médical*, May 30, 1863.

2. Three children were vaccinated at Ménilmontant, from an eleventh-day pustule, the sole product of six insertions, which yielded a considerable quantity of pus. The vaccinifer died, covered with pustules. One of the children presented a chancreous ulcer on one arm, with an axillary adenopathy of the same side, syphilitic ecthyma, and grave lesions of the mucous membranes. The two other children had regular vaccinia, without syphilis.

3. Two children presented supposed syphilitic symptoms "after vaccination." No other facts mentioned.¹

4. Two ladies, about thirty years old, were revaccinated by a midwife from the arm of a nursling. Blood was said to have been drawn from the vaccinifer's vesicle. A month or six weeks afterwards one of the ladies consulted a provincial physician, who communicated the facts to Auzias. The vesicles had not cicatrized. On the left arm there was a deep, violet-colored ulcer, covered with a crust, which was renewed from time to time. On the right arm were two shallower ulcers of the same character. The axillary and cervical ganglia were engorged, and there were nocturnal pains. Soon a copper-colored roseola overspread the body, and the ulcers began to heal. Afterwards a mucous patch appeared on the perinæum. There were no lesions of the genitals, or of the inguinal glands.

The second lady suffered from like manifestations on the arms, afterwards from ulcers on the tonsils, and, two months after the vaccination, from superficial ulcerations of the genitals. The physician examined the husbands, and could find in them no trace of syphilis. The vaccinifer had been returned to its parents, and could not be examined. A third person, vaccinated at the same time, declined an examination, and evaded questions.

XXVII. JONES'S CASES.² Most of these occurred in the Confederate army.

1. In the 12th and 16th Georgia regiments a great number of soldiers vaccinated themselves from the arm of "a comrade of very dissolute habits," who presented unmistakable evidences of syphilis. "They selected the worst sores for the propagation of the virus." More than a hundred of these soldiers developed symptoms which were looked upon as syphilitic.

2. A man was vaccinated from a syphilitic woman, and afterwards developed syphilis, which seems to have begun with initial lesion on the arm. Method of operation not stated.

3. Fifty-two soldiers, who had been vaccinated from a sailor who had primary syphilis, presented symptoms regarded as syphilitic, both primary

¹ These cases are quoted by Auzias, from Alphonse Leroy's *La Clef du Cabinet des Princes*. 10th year, obs. 11 and 12.

² Published by Joseph Jones, M.D., in his *Researches upon "Spurious Vaccination,"* etc., Nashville, 1867.

and secondary. Method of vaccination not stated. They recovered under mercurial treatment, with the exception of one who died.

4. Two married ladies, who, as well as their husbands, were beyond suspicion, were vaccinated, and subsequently developed what was regarded as syphilitic rupia. Initial lesion not mentioned. Method of vaccination not specified.

5. A colonel commanding a post, during a severe epidemic of small-pox, after having been twice unsuccessfully vaccinated with reliable virus by the surgeon in charge of the Madison (Confederate) Hospital, at Greenville, Tennessee, in his eagerness to get up a sore, got himself infected with what the surgeon regarded as syphilitic virus. The soldiers and sailors of the vicinity, equally eager, were in great numbers inoculated from the "ugly-looking ulcer" on the colonel's arm. Many of them developed symptoms apparently syphilitic.

6. Dr. W. F. Percival, of Aiken, South Carolina, wrote to Dr. Jones as follows: "About the last of April, 1866, I was requested to take charge of some cases of spurious vaccination. . . . One hundred and fifty were presented for examination,—men, women, and children,—of all ages, from fifty years to twelve months. . . . Ninety-three had been previously vaccinated. The appearance of the sore was identical in every case, viz.: an excavated ulcer of circular form, with raised and hardened edges and base, . . . from one half to two inches in diameter, covered with gray or dark sloughy matter, and secreting unhealthy pus. There was no appearance of granulation. In some cases ulcers of a similar character appeared on the arms affected; in others, on the opposite arm, and in a few on the lower limbs." Abscesses, copper-colored eruptions, alopecia, etc., followed in some of the cases. Those first vaccinated had obtained the virus from a man afterwards discovered to have had primary syphilis. "One was vaccinated from another, and so it spread." The subjects were for the most part laboring people, and in various conditions of health. Anti-syphilitic treatment was followed by cure in from three to six weeks.

7. Dr. Jones quotes from an article by Dr. Hubbard,¹ a surgeon of U. S. Volunteers, in which an account is given of hundreds of soldiers and citizens who suffered from what was looked upon as syphilis, and which followed inoculation with virus from deserters from the Confederate army, which evidently possessed no vaccinal energy.

XXVIII. MONELL'S CASE.²—This case was reported by Dr. Monell at a meeting of the New York Medical Association. "The patient was a boy, nine years of age. The mother gave the history of the case as follows: Its parents were both healthy before and at the time of its birth. The child was also healthy until the age of six years, when it was inocu-

¹ *Phil. Med. and Surg. Reporter*, February 10, 1866, p. 103.

² *New York Med. Times*, August, 1854, p. 404.

lated in Ireland, with small-pox virus. An ulceration occurred at the place of inoculation, which was a long time healing; and a general eruption also occurred, which remained for months. At the present time there are several copper-colored spots on the arms. Eight days ago a sore-throat commenced, and two days ago laryngitis occurred; and he is now moribund."

XXIX. GLATTER'S CASE.¹—"A midwife got an unhealthy sore on her forearm while assisting in the confinement of a woman who was afflicted with syphilis. She continued to nurse her little grandchild, and to carry it in her arms. The child, apparently healthy, was vaccinated, and most of the children in the place were inoculated with lymph taken from it. In these infants the pustules passed into spreading ulcers; affections of the mouth and condylomata about the anus also showed themselves. Fissures appeared on the nipples of the mothers who suckled their children, and the affection reached even their husbands."

XXX. HAYDON'S CASES.²—In 1843, a public vaccinator, in Bodmin, in the county of Cornwall, England, vaccinated two children of different families, each being between nine and ten months old. Between the second and third week after the vaccination the children were "literally covered with large phlysiaceous pustules, the irritation was most intense, and between rubbing and scratching, the head and nates were raw and ulcerated." In spite of treatment, both children died in a few days. In both families there were other older children perfectly healthy. Dr. Haydon considered the disease to be syphilis. He had no doubt that the children's parents were healthy. The vaccinifer's mother was on the town, and Dr. Haydon had attended her for syphilis. He examined her child (the vaccinifer), which was between two and three years old. There were no primary syphilitic sores, but "numerous syphilitic eruptions about its body, pustules about its nates and trunk, and copper-colored leprous spots." It recovered under treatment.

XXXI. HEINE'S CASES.³—Thirteen children, born of healthy parents, were vaccinated with lymph taken from a child whose mother was syphilitic, and which itself was at the time covered with bullæ, excoriations, and sores, and which soon afterwards died. Nine of these children were immediately affected by syphilis; phagedenic ulcers were formed at the points of inoculation, and glandular swellings, condylomata, etc., followed. In two of the four children who escaped syphilis, either the vaccination produced

¹ *Oesterr. Zeitschrift für prakt. Heilk.*, viii., 4; *Canstatt*, vii., 69, 1863. *New Sydenham Society's Year-Book of Medicine and Surgery*, 1863, p. 468.

² *Med. Times and Gazette*, March 29, 1862, p. 316.

³ Heine's *Beiträge zur Lehre von der Syphilis*. etc., Würzburg, 1854, quoted by Bamberger in a clinical lecture. See *Medical Notes from the Continent*, etc., in *Ed. Med. Jour.*, December, 1858, p. 604.

no effect, or the vesicles never matured, and in the remaining two cases no result ensued, as the mothers, alarmed at the aspect of the child from which the lymph was taken, had removed the vaccine virus from the arm as soon as they could.

Heine also records the case of three young physicians, who inoculated themselves with vaccine lymph from a syphilitic child, as a piece of fool-hardy bravado; and two of them suffered from unmistakable syphilitic sores, etc., in consequence.

XXXII. SEBASTIAN'S CASE.¹—This case was communicated to the French Academy of Medicine, by Dr. Sebastian, chief physician of the *maternité* at Béziers, and is here translated from his own account, quoted by M. Blot:—²

“On the 19th of March, 1863, a woman named A. M. came to me with a child six months old, which had been vaccinated eight days before, and desired me to vaccinate the children of two friends of hers who came with her. In opening the vesicles, which were well developed and presented no abnormal appearance, *I was careful not to draw blood*. At the moment of my taking the vaccine for the last insertion in the second child, the vacciner made a slight movement, the point of the lancet penetrated deeper than was intended, and the lymph became streaked with a little drop of blood, but was nevertheless, to my regret, inoculated. Twenty-two days afterwards this child was brought back to me. The vaccinal vesicles were perfectly normal, *except that from the last puncture, the position of which I well remembered*. This vesicle presented the appearance of a ‘pseudo-chancere.’ It was surmounted by a conical crust, dark-colored and glossy, about 2 *centimètres* in diameter, and slightly ulcerated at the periphery. Around it, within a radius of a *demi-centimètre*, there were numerous lenticular papules, smooth, regular, and of a pale red color. In the axilla of that side there was a small engorged gland, movable and tender. Forty-nine days later the pseudo-chancere had ulcerated, and presented considerable induration. The child's body was covered with a syphilitic roseola, and there were characteristic *plâques* on the genitals.”

The vacciner was found to be syphilitic. The other vaccinated child escaped syphilis.

XXXIII. WEGELER'S CASES.³—These cases occurred at Coblenz, in 1849. The vaccinator was a veterinary surgeon, known in the literature of this subject as “Le Vétérinaire B.” During an epidemic of small-pox twenty-six persons were re-vaccinated from a child said to be healthy, but who a few days afterwards showed syphilitic roseola, and ten days later died hydrocephalic. His vaccinia was retarded. He was used as a vacciner on the 10th, 11th, and 12th days. In the re-vaccinated persons, the vaccinal

¹ *Gazette des Hôpitaux*, October 22, 1863.

² *De la Syphilis Vaccinale*, p. 49; Ballard, *op. cit.*, p. 348.

³ *Preuss. Verein zeit.*, No. 14, 1850.

vesicles [if any occurred] were in three or four weeks transformed into syphilitic ulcers, followed in most of the cases by constitutional syphilis. The vaccinator was punished by two months' imprisonment and a fine of 50 thalers.

XXXIV. CASE REPORTED TO FRENCH ACADEMY BY M. DEPAUL.¹—M. X., an adult, the "nephew of a well-known specialist physician," together with some soldiers, and nine children, were vaccinated from apparently perfect vesicles on a pale and rather miserable-looking infant, whose history, afterwards traced, left no doubt that it had constitutional syphilis. All the vaccinated were infected. The mother [of the vacciner?] and the vaccinator, an employee of the Academy, declared that care had been taken not to draw blood.

XXXV. DEVERGIE'S CASE.²—"On the 11th of March, 1863, a carpenter's apprentice, æt. fifteen years, was admitted into the St. Louis Hospital. He was born of healthy parents. Some months before his admission he had been treated at the Ste. Eugénie Hospital for a slight pleurisy. He was at that time vaccinated in two places on the right arm, and with the same lymph (taken from a nursling) on the same day a number of other children were vaccinated. On the third day a small brown crust had appeared at the point of insertion of the virus, and the physician had declared that the vaccination was not taking. The crusts kept growing larger, but the patient gave himself no concern, and did not again submit his arm for examination before leaving the Ste. Eugénie Hospital. Five or six weeks after the vaccination rashes appeared on the extremities in successive outbreaks, and finally involved the whole surface. In the third month the voice was hoarse, and there were nocturnal pains in the bones. The exanthem was of the tubercular sort, the tubercles were of a brownish-red color, and from a *millimètre* to a *centimètre* in diameter. Three hard tubercles were situated on the foreskin, and a moist one on the scrotum. The left inguinal glands were slightly swollen. The two vaccinal punctures on the right arm were still surmounted by brown crusts, adjoining which a portion of skin four *centimètres* in extent was thickened. Right axillary glands markedly indurated, left normal. Iodide of potassium, corrosive chloride of mercury, and *holzthee* completely cured him in six weeks.

XXXVI. TROUSSEAU'S CASE.³—This case occurred in M. Trousseau's service at the Hôtel Dieu in 1861, and was communicated by him to the French Academy. A newly-married woman, 18 years of age, who was

¹ *Gaz. Méd. de Paris*, October 7 and 12, 1867, quoted in *Med. Times and Gaz.*, May 16, 1868.

² Quoted by Auspitz, *op. cit.*, from *Bull. de l'Académie*, XXVIII., p. 664, May, 1863.

³ *De la Syphilis Vaccinale*, p. 69.

under treatment for a uterine catarrh, was, together with five children, vaccinated from an apparently healthy child. The vesicles fell short of perfect development, and she soon afterwards left the hospital. Two months after the vaccination she again presented herself, with two rupial pustules on the left arm, at the point of vaccination, which Trousseau considered to be vaccinal vesicles unusually retarded and anomalously developed. At the end of another month she appeared with the ulcers still unhealed and suppurating, situated on indurated bases. There was axillary adenopathy, with roseola and other symptoms of general syphilis. M. Ricord now saw her, and considered the lesions on the arm to be undoubted specimens of the *ulcus elevatum*.

The vaccinifer was not shown to have been syphilitic. The five children remained healthy.

XXXVII. THE LUPARA CASES.¹—These cases occurred in 1856. Dr. Marone vaccinated a great number of children with some lymph preserved in tubes, which he had obtained from Campobasso, and which appeared to contain blood. Twenty-three of these children were attacked with syphilis, commencing with its initial lesion on the arm at about the time the vaccinal crusts were shed. In this case, also, the disease spread to parents, nurses, etc. The child which furnished the lymph was afterwards ascertained to have died, a short time after her vaccination, of an eruptive disease, the character of which does not seem to have been made out.

One of the infected children, Filomena Littorti, furnished lymph for additional vaccinations, and eleven children were contaminated, and conveyed the diseases to their mothers, nurses, etc., as in the first series. Marone had never before observed syphilis among the peasants of Lupara.

XXXVIII. HÜBNER'S CASES.²—These cases occurred at Freienfels, in Upper Franconia, in 1852. No investigation was made until eight months after the occurrence. Hübner, the vaccinator, was an homœopathic practitioner. The vaccinifer was an illegitimate child, 3 months old, named Keller, whom Hübner declared to have been healthy at the time of the vaccination, but who died of atrophy two months afterwards, and who, according to his mother's statement under oath, had, at the time of the vaccination, pustules on its legs. At the time of its birth the mother had suspicious ulcerations of the mouth and genitals, which healed under anti-syphilitic treatment. An infant, which slept in the same bed with the child and its mother, did not become infected with syphilis.

Thirteen children, stated to have been healthy and of healthy parentage,

¹ *Imparziale de Florence*, No. 5, 1862, quoted in *De la Syphilis Vaccinale*, p. 108. Auspitz' account of these cases is very incomplete.

² *Schmid's Jahrb.*, LXXXIII., 238; Paoli's Defense of Hübner; *Intelligenzblatt baier. Aerzte*, 1854, quoted by Auspitz, *op. cit.*

were vaccinated from Keller. At the end of eight months eight of these children and nine mothers were found to be suffering from constitutional syphilis. The relatives recounted the transformation of the vaccinal punctures into ulcers, and the appearance of eruptions about the anus and genitals three months after the vaccination.

From one of these eight infected children twenty-five or thirty children of another parish were vaccinated, and one of them was infected with syphilis.

From one of the five children who escaped infection from Keller twenty-five others were vaccinated, of whom also one became syphilitic. In this case the vaccinifer is known to have remained healthy for ten months after the vaccination. Hübner was punished by six weeks' imprisonment.

XXXIX. ADALASIO'S CASES.¹—These cases occurred at Torre de Busi, near Bergamo, in Italy, in 1862. Quarenghi vaccinated six children from tubes of lymph taken by himself from a child, who, at the time, had a cutaneous eruption supposed to be varicella, but which Viennois considers to have been a syphilide. Five of these children developed syphilitic initial lesion at the point of vaccination, followed by general symptoms. The disease was widely spread among their families. It is not known whether the child which escaped contamination came first, or in some other position, at the time of the vaccination. From one of these five infected children five other children were vaccinated, in two of whom there ensued a cutaneous eruption, which, in all probability, was not syphilitic. From one of the latter five children three others were vaccinated, and remained perfectly healthy.

Adelasio has recorded another case, which occurred at Alma in 1863. The infant daughter of a physician had been put to nurse with a woman who had on her breast a fissure, which had aroused the suspicions of an *accoucheuse*. Three months afterwards the child had syphilitic manifestations, and was vaccinated at the same time with "a whole series" of children, all of whom remained healthy. Her father vaccinated from his daughter two children, whose mothers stated that no blood was drawn from the vaccinifer. In these two children the crusts were tardily shed, and gave place to ulcerations. About two months after the vaccination general syphilitic manifestations appeared.

XL. THE RIVALTA CASES.—These cases occurred in 1861, at the village of Rivalta, near Acqui, in Italy, and were described by Cerisse,² and afterwards by Pacchiotti.³

¹ *Relazione sopra casi di Sifilide*, etc., dal Dr. G. I. Adelasio, Bergamo, 1864; *L'Imparziale*, Nov. 16, 1864; *Bulletins de la Société de Méd. d'Amiens*; Viennois, *Arch. Gén. de Méd.*, 1860.

² *L'Union Médicale*, Nov., 1861, to Feb., 1862, quoted by Ballard, *op. cit.*

³ *Sifilide Transmissa per mezzo della Vaccinazione in Rivalta, presso Acqui*. Turin 1862. Quoted by Auspitz, *op. cit.*

A surgeon named Cagiola obtained from the lymph-depot at Acqui a tube of vaccine virus, with which he vaccinated Giovanni Chiabrera, a child 11 months old, who at the time appeared healthy, but who was afterwards ascertained to have been, two months previously, in contact with, and even to have taken the breast of, a woman who was proved to have constitutional syphilis, and who had infected her sister's child by suckling, and, through the latter, her sister. Giovanni's father, although reputed a "*discipolo di Venere errante*," was healthy, and showed no signs of previous syphilis. Syphilis is said to have been previously unknown in the village, which contained about 2,000 inhabitants. Ten days after the vaccination the child began to suffer from weakness, swelling of the mesenteric glands, and (after a month) severe diarrhœa. There was erythema about the anus, an excoriated tubercle on the foreskin, and complete baldness of the head. The child died in about six months after the vaccination, having first infected its mother on the breasts.

On the tenth day from Giovanni's vaccination, forty-seven other children were vaccinated from his arm, and, as was afterwards ascertained, some blood was observed on the lancet at this vaccination. Of these forty-seven children, nine (who were among the last vaccinated) escaped syphilitic infection, and thirty-eight subsequently (after a lapse of from ten days to two months) developed syphilis, which seems to have commenced with the initial lesion at the point of vaccination.

One of these thirty-eight infected children was Luigia Manzone, six months old. On the tenth day from her vaccination, before her syphilis manifested itself, she afforded lymph (by the arm-to-arm method) for the vaccination of seventeen other children, of whom seven developed syphilis.

More than four months after the vaccinations the epidemic was first brought under medical investigation by Dr. Pacchiotti and his associate commissioners, who observed its further progress, and obtained some additional facts. At this time six of the children had already died, and the others were suffering from cutaneous eruptions, broad condylomata, ulcers, iritis, and alopecia. In all the cases these symptoms made their appearance later than the tenth day after the vaccination. At the vaccinal punctures, all had ulcers, or papules, or copper-colored, in a few cases white, cicatrices.

The disease spread by contagion, so that in eight months from the vaccinations Pacchiotti had observed forty-six children, twenty-six mothers and nurses, five husbands, and three brothers and sisters of the vaccinated, attacked.

Concerning the origin of the syphilitic disease in the first vaccinifer, Chiabrera, Dr. Pacchiotti's subsequent narration is thus summarized by Mr. Henry Lee:¹—"About a year and a half previously a young woman

¹ *Lectures on Some Subjects connected with Practical Pathology and Surgery*, 3d edition, London, 1870, Vol. II., p. 154.

(who said that she had been infected by a child from Acqui) had had constitutional syphilis at Rivalta, and he had ascertained that her symptoms continued for some time before the vaccination at Rivalta. This woman was the mother of a child, which she suckled, and which died three months after its birth. It was reported by some to have died syphilitic, and by others to have been suffocated in its cradle. After the death of her child, she required her breasts to be drawn, and Chiabrera's mother undertook the office herself, and lent Chiabrera (the first vaccinifer) to the woman for the purpose. The woman, in return, gave Chiabrera her own child's clothes. The woman, whose name was Libérate, after the death of her child, went to live with her sister Mary, who also was suckling an infant. Libérate, in the absence of her sister, suckled Mary's child. At the end of a certain time, not only was Mary's child infected, but Mary was herself infected through her own child. Now, as this nurse infected her own niece, it appears in the highest degree probable that she had also infected Chiabrera, whom she had nursed. All this took place two or three months before the vaccination of Chiabrera. That the woman Libérate and her sister and her sister's child were really affected with syphilis, is substantiated by a medical man at Acqui, who attended them. Subsequently Professor Sperino saw them at Rivalta with syphilitic symptoms. They are now, says Dr. Pacchiotti, at Turin, as patients in the 'Sifilicomicio.' "

We have now given all the reputed cases of vaccino-syphilitic inoculation to which any importance can be attached, together with not a few so sparingly detailed as scarcely to be worthy of serious discussion. In many of them there is room for grave doubt as to whether or not there was any syphilis in the case, but in most of these it has seemed desirable to concede the syphilitic nature of the disease, as that could be done in far fewer words than would be required for laying the full details of symptoms before the reader.¹ It is undoubtedly true that there have been many cases, which have never been published, which have as much bearing on the question under

¹ The difficulties which beset a retrospective diagnosis in cases of this sort, are of course much greater than in cases which are actually before us, and that these latter are by no means small, is evidenced by the fact that that most accomplished syphilographer, Mr. Henry Lee, once announced to the Medico-Chirurgical Society of London, that he had under his care a case of chancre produced on a child's arm by vaccination, the subsequent progress of which, however, satisfied him that he had been mistaken in the nature of the sore, which he publicly acknowledged not to have been syphilitic.

discussion, as have most of those above cited, but it is extremely unlikely that there have been any that could be called stronger than the strongest we have given. It is not very uncommon to hear practitioners allude to some case which has fallen under their own observation; but, so far as these have been brought to our attention, they have always been found strikingly deficient in essential particulars.

To resume our commentary on the clinical observations. The Tassani affair first came under medical observation, after the lapse of a year from the time of the vaccination. As regards the vaccinifer, there is no evidence that its syphilis was contracted at Befutrafio, for there is no account of an initial lesion, but its father gave a history of primary syphilis in his own person. Of sixty-four vaccinated children, an uncertain number developed the initial lesion of syphilis at the vaccinal punctures. We are not told in how many of them this happened, nor whether they were the earlier or the later of the series. In short, there is nothing to indicate that the syphilis was inoculated from the vaccinifer's arm. In all probability one or more of the vaccinated children were syphilitic before the vaccination, and communicated the disease to the others. Upon this point more will be said when we come to the consideration of the Rivalta cases.

In Ceccaldi's cases there is every reason to suppose that the infection was, in like manner, conveyed from one of the vaccinated children to the others. Taking into account the diverse ages of the children, and the fact that they belonged to two different families, we are not disposed to adopt Viennois' theory that the vaccination merely developed the evolution of a pre-existing syphilis.

Bonnière's case is a striking instance of the conveyance of syphilis by blood inoculation, and of the method of multiplied infection, to which we have imputed the disease in Tassani's cases.

In Viani's cases, we cannot be sure that there was no admixture of the vaccinifer's blood with the vaccine, or that there was not some remaining syphilitic lesion besides the ophthalmia to furnish the source of contamination.

Drysdale's case is very insufficiently described. There is not sufficient evidence of an initial lesion, and moreover the time which elapsed between the vaccination and the appearance of general symptoms was so short, as, of itself, to throw great doubt on the supposition of inoculated syphilis.

The Lyons cases are open to the same objection with those of Mr. Solomon, mentioned in the first portion of this paper, which applies equally to Lecoq's, Auzias-Turenne's fourth case, and especially to Trousseau's, in the consideration of which last case we shall revert to this objection.

Galligo's cases were manifestly examples of blood inoculation, though less pronounced than Sebastian's case. The same may be said of Lecoq's cases, in addition to the objection above mentioned.

In regard to Aliès' cases, in the absence of specific data, we shall have to content ourselves with the criticism of M. Bonquet, already quoted.

In Houghton's case, the absence of any account of initial lesion, and the supervention of secondary symptoms "almost immediately" after the vaccination, utterly preclude the conclusion that the disease was inoculated along with vaccinia.

In Morax's case we know nothing of the vaccinifer, except that it was said to be an "ill-conditioned child." It may have been the subject of syphilitic lesions, of which the secretions were inoculated, or the case may have been one of blood inoculation. At all events the data are not sufficiently precise to enable us to say that the syphilis was conveyed by vaccination with unmixed lymph.

In Laroyenne's, we know still less, absolutely nothing, of the vaccinifer, or of the mode in which the operation was performed. Chassaingnac's case is open to the same criticism, as is also Hérard's, which moreover is even more meagrely reported. In Rodet's case we are informed that the vaccinifer had shown syphilitic manifestations, but whether lesions existed at the time of the vaccination, or whether or not blood was drawn in taking the lymph, we are not told. In Bergeron's case there was probably no syphilis present at all.

In Auzias-Turenne's first and third sets of cases, especially

in the third, the data are so meagre, that, for reasons previously given, they cannot be taken into account. In his second group of cases the question arises, whether or not, supposing eighth-day lymph to be innocuous, the purulent fluid which ordinarily constitutes the contents of the vesicle after that time may partake of the diathetic peculiarities of the subject bearing it. Three children were vaccinated from an eleventh-day pustule, and only one of them became syphilitic. Why did the two others escape? It is possible that the two were vaccinated with concreted lymph which, having exuded at an earlier date, was adhering to the outside of the pustule, and that the child who became syphilized was vaccinated after the two others with matter from the interior of the pustule, which may have been mixed with blood from wounded capillaries at the bottom of the pustule, or with white blood-corpuscles escaped from them.¹ As far as this case goes, it contains too many elements of uncertainty for us to look upon it as furnishing an exception to the law that morbid secretions from non-syphilitic lesions in syphilitic subjects are not inoculable. This aspect of the question will be considered more at length hereafter.

In Anzias' fourth set of cases, if syphilis was conveyed from the vaccinifer at all, it was through the medium of his blood. The objection that the syphilized persons were adults, and therefore liable to contract syphilis in other ways, is weakened by the very significant fact that, out of three vaccinated persons, two had syphilis which began with chancre at the point of vaccination, and the third, by declining an investigation, gave ground for suspecting a like result. On the other hand, however, I cannot refrain from suspecting that this third person was previously syphilitic, and conveyed the disease to the two others at the time of the vaccination, by reason of the same instrument being used for all three. It would be interesting to know which of the three was vaccinated first, although this is not essential to our theory, unless it be shown that the

¹ This latter conjecture must stand or fall with the truth or falsity of Cohnheim's observations (see Virchow's *Archiv*, XL, p. 1). And the secondary question arises, whether or not syphilis may be conveyed by one morphological element of the blood alone

method of operating was by inserting the virus into the punctures on the first person before making the punctures on the others. Our view of the case is countenanced also by the fact that the vaccinifer was not ascertained to be syphilitic.

Jones' cases are very unsatisfactorily narrated. Those that occurred in the Georgia regiments were probably examples of inoculation with syphilitic secretion. In the second, third, and fourth series of Jones' cases, the obscurity in which the circumstances attending the operation are involved renders them unworthy of being considered in this connection. Jones' fifth case is of the same sort as his first. His sixth case is one of inoculation from the same source. We cannot be sure whether any of the sufferers were really vaccinated, or at what stage of the resulting lesion virus was taken from the arms of the earlier victims for insertion into those of the later. Hubbard's cases appear to have been of a similar character.

Monell's case has no bearing on the question under discussion, except of an analogical nature. It was a case of inoculation with small-pox virus—variolation. Admitting that syphilis was inoculated at the same time, we know nothing of the subject which furnished the variolous virus, or of the pains which were taken in the operation, to avoid blood-inoculation.

In Glatte's case, it is probable that the first child took its syphilis from its grandmother, by the secretion from her chancre having been brought in contact with the vaccinal punctures, and it is fair to suppose that such secretion was allowed to remain on the vesicle, and was transposed to the other children along with the vaccine lymph. In other words, the case was one of inoculation of two distinct viruses—that of vaccinia, and that of syphilis.

Haydon related his cases nineteen years after they occurred—*primâ facie* evidence of inaccuracy. There is no account of initial lesion in the two children, and the supposition that the disease of which they died was inoculated syphilis, is very much weakened by the fact that the time which elapsed between the vaccination and the appearance of the alleged constitutional syphilis was only between two and three weeks.

In Heine's first set of cases there was undoubtedly gross

malpractice. Syphilis was unquestionably conveyed in vaccination, but will any one believe that the lymph was not mixed with the secretions from the syphilitic lesions? In the case of the three young physicians who vaccinated themselves with lymph from a syphilitic child, there may have been admixture of blood, or of syphilitic secretion, or of both. There is great poverty of detail in the account.

Sebastian's case is very properly characterized by Ballard as a "crucial observation." It was evidently a case of blood-inoculation.

In Wegeler's cases, "Le Vétérinaire B." swore positively to having made an extraordinarily minute examination of the vaccinifer, but it appears that the child showed syphilitic manifestations "a few days afterwards," and the supposition that it was free from them at the time, rests only on the testimony of a man who was so ignorant or so criminal as to use the vesicle on the *tenth, eleventh, and twelfth days*. And on this same testimony we are asked to believe, also, that the vaccinifer's blood was not mingled with the lymph. The case counts for nothing.

In the next case, reported to the French Academy by M. Depaul, the testimony, it is true, attempts less, but it achieves no more. Those who are familiar with the literature of vaccination will perhaps remember, *à propos* of the *employé*, M. Blot's description of such a functionary. "An old valetudinarian, utterly ignorant of the healing art, and the victim of senile tremor, I need not say whether this worthy was capable of selecting subjects, and interrogating mothers. At all events, if he were capable of it, he did not take the trouble to do so."¹ The case may be dismissed, then, with no more comment than was given to Wegeler's.

Devergie's case is weak, in that the account of the supposed initial lesion is unsatisfactory, that the subject was of an age to have incurred syphilis in the ordinary way, and that nothing is said of the vaccinifer, or of the mode in which the vaccination was performed.

Trousseau's patient was an adult, and also an abandoned

¹ *De la Syphilis Vaccinale*, p. 54.

woman, whom M. Trousseau characterized as a *notissima fossa* of the *Closerie des Lilas*. As she was the last of a group to be vaccinated, and as M. Trousseau regarded it as pretty certain that, by the time her turn arrived the vaccinifer's vesicle (opened on the fifth or sixth day) had been so injured that blood became mixed with the lymph, the case might fairly be regarded as one of blood-inoculation, provided the vaccinifer were known to be syphilitic. Such, however, is not the case. We must therefore attribute this woman's syphilis to a subsequent application of syphilitic virus to the vaccinal punctures. The annals of syphilis are not wanting in cases in which chancres have been met with on various parts of the body. It would seem that the *Closerie des Lilas* might furnish the facilities for such inoculation.

The Lupara cases were not made known until six years after they occurred, Dr. Marone having naturally shrunk from publishing an affair which would probably redound to his discredit, and, as he says, aid in bringing vaccination into disfavor. The publication of Pacchiotti's cases, however, induced him to break silence. In these cases syphilis was unquestionably communicated by vaccination, but evidently not by pure vaccine. We are told that the vaccinifer (who furnished the tube of lymph obtained at Campobasso) died soon after her vaccination, of an eruptive disease—probably syphilis, as its character does not seem to have been accurately made out, as it probably would have been had it been one of the exanthematous fevers. The tube, then, may have contained a quantity of secretion from a syphilitic lesion, and it probably did contain blood, although Dr. Marone's testimony on this point would have been of more value if it had been given before the publication of Viennois' essay. So far, then, as regards the first series of children—those vaccinated directly from the Campobasso lymph—we are at no loss to account for the syphilis from which they suffered. But how shall we explain the syphilization of the eleven children of the second series, who were vaccinated from the arm of Filomena Littorti? We have no reason to suppose that she was syphilitic before her vaccination, and if her vesicle was made use of at any time during the term

which ordinarily and properly limits the use of a vesicle as a source of lymph, she certainly could have presented no syphilitic lesion. Was the infection caused by the use of the same instrument that had been used in the first series, and that might still have remained contaminated with the Campobasso lymph? There seem to be only two objections to this theory, viz.: (1.) We are not *positively told* that the same instrument was used in both series, but, judging from the slight amount of care usually bestowed on the performance of vaccination, there would seem to be little doubt that such was the case; (2.) This supposition would do violence to Boeck's opinion of the fugacious nature of the contagious element of syphilitic matter. I confess that these objections do not seem to me insuperable, but, leaving this explanation out of account, we must next consider the applicability of the theory of blood-inoculation; and here arises the question of whether or not the blood of a person incubating chancre is capable of conveying syphilis, knowledge, we cannot definitely answer. However much and this is a question which, in the present state of our analogy may incline us to an affirmative answer, we must, in the absence of experimental proof, decline to attempt the explanation of a case of vaccino-syphilitic inoculation in this manner. Ballard¹ supposes that a portion of the original virus implanted in Littorti's arm was bodily transferred to the vaccinated children. The continued activity of the virus he imputes to a supposed "*local reproduction*." But if syphilitic virus lay dormant in Littorti's vesicle, why were not all the children of the second series syphilized? Let us remember that a vaccine vesicle is multilocular, and that in this case some of the compartments may have contained remnants of the Campobasso lymph, while others may have contained only the lymph nominally formed in the process of vesiculation. In view of all the facts, this hypothesis seems to me to be warrantable; but another, which I prefer, will be mentioned hereafter. At all events, the fact that some of the children of the second series escaped syphilis, although they developed vaccinia, per-

¹ *Op. cit.*, p. 334.

fectly demonstrates the fallacy of assuming the syphilis to have been conveyed by a lymph of which the molecules were both vaccinal and syphilitic through and through.

In Hübner's cases, in all probability the first vaccinifer, Keller, was the subject of congenital syphilis, and the statement of its mother would lead us to suppose that it showed manifestations at the time of the vaccination. The contagion may have been conveyed to the eight children in either one of the three following ways: (1.) by admixture of the secretion from a syphilitic lesion on the child; (2.) by admixture of blood; (3.) from the child's vesicle having been smeared with the secretion from a lesion on the person of the mother. The child who was infected from one of the eight may have received the disease in one of the methods mentioned when speaking of the second series of the Lupara cases, or by the method last mentioned, which method would seem to be the only one by which the one child of the third series became infected from one of the five of the first series who escaped syphilis. In this case, then, we have no proof of the vaccine lymph having, as such, been the source of syphilis.

In Adelasio's first set of cases, the tubes of lymph, there is reason to suppose, contained fluid from a pustular syphilide, Quarenghi's recollections to the contrary notwithstanding. In the Alma cases there would seem to be only one way of explaining the conveyance of syphilis, viz., that the vaccinifer (the physician's child) was at the time really suffering from manifestations, the secretion of which must have become smeared over her vesicle. We have the positive statements of the mothers of the affected children, that the vaccinifer's blood was not drawn in the operation. It is possible that blood had been *effused* into the vesicle, and thus been unwittingly conveyed along with the vaccine.¹

¹ It has often been my experience, on examining a vaccinal vesicle, to find it presenting, either in a portion or the whole of the circle, the appearance of containing blood. This may have been the effect of previous rough handling, unconnected with diathesis, but from my own observation I am persuaded that it is more usual in persons (whether children or adults) who are the subjects of syphilitic taint than in others. The appearance would always arouse my suspicions, and restrain me from taking lymph from the subject.

We must now consider the last of our series of clinical facts—the celebrated Rivalta cases. As regards Chiabrera, his syphilis certainly antedated his vaccination. This is proved by the absence of initial lesion at the point of vaccination. The disease was probably derived from the syphilitic woman who occasionally suckled him.

Of the forty-seven children vaccinated from Chiabrera, the nine who escaped syphilis were *among the last vaccinated*. This, at first sight, is rather startling, in view of the fact that, as a rule, blood-inoculation is most apt to occur toward the close of a series of vaccinations. Yet there is no doubt that thirty-eight children were syphilized by blood-inoculation, and the difficulty is done away with by Dr. Pacchiotti's suggestion that the nine children owed their escape to the fact that a fresh vesicle was opened for them.

From Luigia Manzone (one of the children syphilized from Chiabrera) seventeen other children were vaccinated, and seven of them developed syphilis—a repetition of what happened in the second series of the Lupara cases. Shall we explain the fact by Ballard's conjecture, above quoted? Possibly he is correct, but I prefer to account for the infection in another way, which was hinted at in the first portion of this paper, when speaking of the Morbihan cases. It seems not unfair to suppose that some one of the seventeen children was syphilitic before the vaccination (for I confess myself sceptical as to syphilis having been previously unknown in the village of Rivalta), and, if such were the case, we need not wonder that some of the other children vaccinated at the same sitting, and in all probability with the same instrument—perhaps without even a poor attempt at cleansing—should have been infected by blood-inoculation, utterly independently of the vaccine. I have no doubt that syphilis has sometimes been conveyed in this way even *from the vaccinated to the vaccinifer*. I long ago made up my mind to this effect, and wondered why none of the very able men who took part in the famous discussion at the French Academy should have advanced the idea. M. Ricord, it is true, seems to have hinted at it, but he failed to follow it up. It is only within a few days (when this article was nearly completed), that I have

had the pleasure of knowing that my views were also those of so able a writer as M. Raymond Petit,¹ from whose *brochure* I translate the following paragraph:—

“In a given series of vaccinations done with the same lancet, unless the operator take the precaution, too often neglected, of washing and wiping the instrument after each vaccination, the prime source of the contagion may be not the vaccinifer, who is perhaps healthy, but one of the vaccinated persons. Indeed, if one of the children constituting the series be syphilitic, the lancet will become charged with his blood; not, it is true, in taking vaccine from him, but, what amounts to the same thing, in inoculating him with it. This blood, transported to the children who follow after the latter in the series, or even to the vaccinifer, in case of fresh recourse to the vesicle, may convey syphilis to all of them, to the vaccinifer as well as to the others. This really happened in a case which M. Lorain observed in 1866, at the Saint-Antoine Hospital, and which he published.”

Bonnière's case, above quoted, will, I think, do away with any doubts as to the possibility of syphilis being conveyed in this way.

Having thus briefly considered the clinical observations upon which the theory of “vaccinal syphilis” rests, and having shown that they fail to answer affirmatively our opening question: “*Has syphilis been proved to have been communicated to a non-syphilitic person by inoculation with pure lymph from a typically developed eighth-day vaccine vesicle?*” it only remains to give the results of experimental inquiry, and to point out the prophylactic measures which shall surely guard us against allowing Jenner's great discovery to become the means of propagating—even in rare instances—a syphilitic taint. This we shall undertake in the next number of the JOURNAL.

¹ *Transmission de la Syphilis par la Vaccination: des Moyens de l'Eviter.* Par Raymond Petit. Paris, 1867. P. 15.

THE TOPICAL TREATMENT OF LUPUS SERPIGINOSUS.

BY FANEUIL D. WEISSE, M. D.,

Clinical Professor of Dermatology, University Medical College.

THE successful treatment of this disease may be justly claimed as one of the triumphs of modern dermatology. Of topical remedies many have been recommended, tried, and found wanting: nitrate of silver, the acid nitrate of mercury, and unguentum hydrargyri iodidi rubri, equal parts, have proved the best in the experience of the past fifty-five years.

In Dr. J. Moore Neligan's "Practical Treatise on the Diseases of the Skin,"¹ there occurs the following passage: "The topical remedy which I have found most useful in the treatment of lupus serpiginosus is the acetate of zinc; the ulcerated surfaces should be touched with the solid salt—care being taken to use a crystal which has not effloresced—twice a day, daily, or every second or third day, according to the degree of activity of the local inflammation, and a lotion containing from three to five grains to the ounce of distilled water should be used, lint wet with it being applied, and the parts covered with oiled silk when practicable." This positive statement does not seem to have attracted the attention it deserved. Acting upon it, I have tried the salt—in a somewhat modified way—and the results may be judged of from the subjoined cases.

The method which I have employed is as follows: The ulcerations are carefully freed of scabs, their surfaces washed and dried, then a crystal of the acetate of zinc is thoroughly applied. A solution of the salt (gr. viij. to ʒj.) is kept constantly applied on lint, with a piece of oiled silk covering it. Where

¹ Second edition, edited by Dr. T. W. Belcher, page 396.

the patient goes about much, an ointment containing the salt (gr. x. to $\frac{3}{4}$ j.) may be substituted for the lotion. The application of the crystals should be repeated once a week, or every two weeks, according as the cicatrization progresses; whenever the healing is slow it is an indication to repeat the cauterization. The pain produced is very intense for the short time that it lasts; if it is too intense to be borne it may be relieved by cold water. The immediate effect observed is, that the surface becomes coated with a whitish film, not so marked, however, as the pellicle of coagulated albumen produced by nitrate of silver. The solution or ointment should be continuously applied, as it favors the reparative process and allays any undue inflammation consequent upon the escharotic.

The following cases, from the clinic for diseases of the skin at the University Medical College, attest the value of this treatment:—

CASE I.—Mary G., aged seven years, small for her age, with fine red hair, freckled skin, anæmic, and insufficiently nourished; gives no history of any hereditary predispositions. In December, 1864, a papule developed on the left ala of the nose, which pustulated and ruptured; a small ulcer remained, which scabbed and had a dark red areola. It spread circumferentially though superficially, cicatrizing at the centre of the diseased surface. In its progress it destroyed the lateral cartilages of the nose, and contracted the openings of the anterior nares. From the nose it extended downward involving the upper lip, passed around the corners of the mouth to the lower lip; laterally to the cheeks as far as the malar bones; upwards over the nose to the forehead, where it spread to either side, including the lower half of the frontal region, the eyebrows, and the upper eyelids. It had never given pain or even local irritation.

December 15, 1865, when the patient was first seen, the centre of the surface above described presented a bridled cicatrix, with here and there points of recurrent ulceration. The circumference of the scar—upon the forehead, left cheek, and lower lip—was covered by closely adherent scabs, which on removal disclosed superficial ulcers upon a swollen ridge of hypertrophied subcutaneous tissue; on pressure this base yielded a doughy feel. *Treatment.*—Oleum jecoris aselli $\frac{3}{4}$ ss—afterward increased to an ounce—with syrupus ferri iodidi gtt. xx; to be taken three times a day, after eating.

March 2, 1866—General condition of the child markedly improved; the less rapid spread of the disease and some levelling of the subcutaneous

hypertrophy are the only local changes that have been induced. Treatment with acetate of zinc commenced; internal treatment continued.

March 24th.—Ulcerations that were touched with the crystals cicatrized rapidly, the cicatrix presenting a nodular appearance. Reapplied the zinc crystals to several points; nitrate of silver (solid stick) applied to one ulcer—solution of the zinc salt and the internal treatment continued.

April 7th.—Ulcerations which were cauterized have cicatrized. The one to which the lunar caustic was applied healed most rapidly. Crystals of the acetate of zinc, the nitrate of silver, and an ointment of the hydrargyri iodidum rubrum (equal parts) were applied to different ulcerated points at a distance from each other. The zinc solution to be applied to ulcerations that had not been cauterized. Internal treatment continued.

April 28th.—Ulcers touched by the crystals have healed, with two exceptions; those to which the ungt. hydrarg. iodid. rubri was applied have not healed; those cauterized with the nitrate of silver have all healed; the ulcerations not cauterized, but to which the solution of the zinc salt was applied, have cicatrized, leaving a nodular scar. Nitrate of silver applied to all unhealed ulcers; internal treatment continued.

June 22d.—Cicatrization complete.

November.—Recurrent ulceration of cicatricial tissue of upper lip, but none upon any portion that had healed under the above treatment. The zinc applications arrested the process very readily.

May, 1870.—There has been no recurrence of the disease, and the scar indicating its ravages has become very much less perceptible.

REMARKS.—This case was the first one that I had met with. Lupus serpiginosus appears to be rather uncommon in this city, compared with its prevalence in European cities. I availed myself of this opportunity to test the comparative merits of various methods of local treatment recommended. Of the three topical remedies used, I was most satisfied with the acetate of zinc. The application of its crystals is not attended with such violent or protracted pain as is that of the others, and the ulcerations heal equally well. As to the internal treatment, later experience has proven that, so far as the healing of the ulcers was concerned, it might have been dispensed with.

CASE II.—*December 5, 1868.*—J. B., aged 43, mason, has always enjoyed average good health, has never had any form of venereal disease. Twelve years ago his face was scalded by the steam from boiling chemicals; the only point that vesicated was on the right side of the bridge of the nose. The face got well without scarring, with the exception of the point of vesication on the nose; this ulcerated and scabbed—bleeding on the removal of the crust, and the ulcer had a red areola. Within a year from

its first appearance, it had spread so that it was one quarter of an inch in diameter. It gave rise to pain, particularly at night. As the ulcer spread, it became deeper and surrounded by a swollen indurated border, continuing to extend during the past twelve years. It has healed at some points of its circumference near the point of origin, but never in the centre. It is aggravated by cold and damp weather. For nine years the patient has worn, during the day, a plaster over the ulcer. At this time the patient presents a circular ulcer below his right eye, involving the cheek and right side of the nose; it has a dusky red areola, and a swollen border—due to hyperplasia of subcutaneous tissue, which yields a doughy feel on pressure, exuding a watery fluid. Flat adherent scabs form upon it, and at times it bleeds. It is one and one-quarter by one and one-half inches in its vertical and transverse diameters. It has cicatrized at some points of the circumference, but never at the centre of the ulcer. It has been advancing very rapidly lately, and threatens to destroy the right ala of the nose. The nose is swollen, and very painful on handling it in the act of using the handkerchief; the sebaceous follicles are distended by sebum, and the right ala is of a livid red color. *Treatment.*—After removing the scabs and cleansing the surface of the ulcer, the acetate of zinc crystals were thoroughly applied, and a solution of the same was ordered to be kept on the parts during the night, and the ointment applied during the day. The sebaceous follicles around the ulcer and those of the nose became emptied by squeezing.

January 4, 1869.—Marked improvement; cicatrization progressing; swelling of nose subsided, and the use of the handkerchief gives no pain. Subcutaneous hypertrophy about ulcer diminished. Treatment continued.

January 11.—Progress of cicatrization; ulcer now reduced to about one-third the size it was December 5, 1868; induration of base has disappeared. The remaining portion of the ulcer has a healthy appearance. All pain in the nose has passed away, and no danger is apprehended of the ala of the nose being destroyed. Treatment continued.

January 25.—Cicatrization going on, but much slower, as it approaches the centre of the original ulcer.

February 8th.—Progressing most favorably; the ulcer is reduced to one quarter of its size at the commencement of treatment. The unhealed portion is crossed by bands of rapidly developing cicatricial tissue. The cicatrix which has formed has presented no recurrent ulcerations; its edge is somewhat elevated and is clearly defined; it has a few nodules upon its upper portion. Up to the present time three applications of the crystals of the acetate of zinc have been made.

October 26th.—Progress of cicatrization has been very slow; it seemed as though the centre of the ulcer was incapable of cicatrizing. Occasion-

ally the nodular points of cicatrix have ulcerated. The zinc treatment has controlled the disease however, so that at present the ulcer has cicatrized, with the exception of a fistula near the centre of the scar and about a quarter of an inch in depth; this fistula has been repeatedly cauterized but to no purpose. Patient has not used the ointment for six months, and has gone without a cover over the spot.

December 16th.—Centre of cicatrix presents a swollen surface involving the fistula; it is somewhat painful and red. The rest of the cicatrix remains as before. I cauterized the tract of the fistula with a crystal of the zinc salt and ordered the application of solution at night. Five drops to be taken twice daily of the solution of potassæ. arsenis was also ordered.

January 2, 1870.—Ulcer has developed upon the tubercle, and upon the cicatrix on the right side of the bridge of the nose. The ulcers are covered by scabs, under which is pus. The central sore is quite painful to the touch and has an inflamed areola. The sol. potass. arsenitis increased to six drops twice daily. The local applications continued at night, and during the day.

January 9th.—Ulcer looks better than it has done for some time. Ulcer on the nose has healed. It is not so painful, is certainly much less inflamed, and discharges less. In probing the ulcer which had increased so as to involve the whole tubercle, I removed a large slough, which formed the entire base of the swelling. Crystals thoroughly applied to remaining excavation. Solution and ointment to be used as before. Solution of arsenic continued at seven drops twice a day.

January 16th.—Ulcer almost filled up, slight recurrent ulceration near inner canthus of the right eye. Headache during past week, and pain on handling the nose. Applied crystals; zinc solution and ointment continued; stopped solution of arsenic.

February 6th.—Ulcer filled up to the level of the cicatrix, two superficial ulcerations remaining; fistula healed; all pain has left, and inflammatory redness has subsided into a pinkish blush over site of last ulceration. The edges of cicatrix are becoming level with the scar. Crystals applied; solution continued; ointment stopped.

February 20th.—Ulceration has healed for the first time in thirteen years. A faint blush indicates the situation of last point of recurrent ulceration. There are three minute points of excoriation covered by scabs. The cicatrix has an irregular surface. Crystals applied to excoriations.

May.—All treatment has been suspended since last visit; there had been no return of the disease, and the cicatrix is becoming less perceptible from week to week.

Remarks.—In this case I resolved to test the value of the

acetate of zinc, and to this end used it exclusively. As to the effects of the solution of arsenite of potash, which was taken for one month, I am not prepared to say. Did it induce the separation of the slough at the last point of recurrent ulceration of the cicatrix? I should be inclined to try it again in a similar condition. I used it with the object of controlling the local inflammatory action. The success of the zinc treatment justifies no little reliance upon the remedy. Other cases might be detailed, but this article has already exceeded the limits I had intended. I cannot, however, refrain from stating that, in the hands of others, the zinc treatment has proved equally successful. Dr. Henry G. Forbes, of this city, has succeeded with it in arresting and healing a lupus serpiginosus, of many years standing, which had already destroyed the greater part of the nose, and was still advancing.

The acetate of zinc, as used above, has in my practice superseded all remedies in the local treatment of lupus serpiginosus. I believe that, if it is carefully used, *it may be relied upon to arrest and heal the ulcers without any other treatment, either topical or internal.*

Selections from Foreign Journals.

ON THE INDURATION OF CHANCRES IN THE
FEMALE.¹

BY ALFRED FOURNIER.

Médecin des Hôpitaux, Professeur agrégé à la Faculté de Paris.

TRANSLATED FROM THE "ANNALES DE DERMATOLOGIE ET DE SYPHILIGRAPHIE,"

BY DR. R. W. TAYLOR.

THERE is another question, not less important than the preceding, and demanding, like it, serious consideration: "*Is induration a constant sign of the syphilitic chancre in women?*" In other words, are indurated chancres in women the sole precursors of constitutional syphilis?

This is a grave question, which, doubtless, you have often heard discussed and answered, in a manner equally bold and frivolous, as follows: "Induration is but rarely developed in woman, and in her the soft chancre, as well as the indurated chancre, may serve as the exordium of syphilis. Consequently, there are no prognostic differences to be drawn between the two forms of chancre, since both result in the same sequelæ. Consequently, also, the indurated chancre and the soft chancre, far from being two independent affections, are only varied expressions of one and the same disease." I hope to convince you of the error of these propositions. From this plain statement of the case you have already perceived that we are in the midst of the most delicate and difficult questions in syphilography.

To the question, as above stated: "Is induration a constant sign of the syphilitic chancre in women?" I feel neither hesitation nor perplexity in replying: "No; induration, as a clinical sign, is not an absolutely constant character of the syphilitic chancre in women. We often observe syphilitic chancres in women, under the base of which it is impossible to perceive induration."

¹ A clinical lecture delivered at the Lourcine Hospital.—Concluded from p. 246.

But, I directly add: "Induration, in women as in men, is an almost constant sign of the syphilitic chancre; it is assuredly, of all signs, the one least variable and least frequently wanting." *In women, as in men, the non-indurated syphilitic chancre is a rare exception.* The absence of induration, in all the cases in which it occurs, is generally due to the local conditions which mask or obscure the symptom, and render its examination very difficult. Beyond these conditions, the non-indurated syphilitic chancre is one of the most exceptional anomalies, a rare pathological curiosity.

Nevertheless, do not mistake the real interest of the question. It is not whether the induration of the base of a chancre in a woman may be absent more or less frequently; it is wholly in the deductions which observers draw from that fact, in order to establish the unity between the non-indurated syphilitic chancre and a morbid variety, wholly different, the simple chancre. Indeed, what does it signify, that induration as a symptom of the chancre should be wanting in men or in women? What is there in that astonishing or unusual? Induration, after all, is but a sign and nothing more. It is the tangible expression of the initial syphilitic neoplasm sufficiently developed to be recognized by the observer. Now, are there many pathological signs which are absolutely constant, and which, to a certainty, are to be found in every case of a given disease? On the contrary, is it not of common occurrence, that diseases often present themselves to observation under forms more or less incomplete, masked, as we term them? And then, they are not only wanting in their accessory symptoms, but often, in their pathognomonic symptoms. Now, if there is any thing pathognomonic in semeiology, it is surely the crepitation of fractures; but is crepitation elicited in all fractures? Certainly not. Can it be wanting, and can a fracture only exist upon the condition of its presenting very distinct crepitation? Such a supposition would be absurd.

Do all pneumonias invariably present the crepitant râle, their essential sign? Certainly not. This sign often escapes the clinical observer, in consequence of the pneumonia being central and deep, or because he is too late to hear it, or for many other reasons. Have we not noticed, in many diseases, the absence of some of their most important and constant signs—the lenticular spots in typhoid fever, the vomiting in cerebral tumors, the fever in diseases essentially febrile, the diarrhœa in cholera, the eruptions in the exanthemata, etc.? And so on in many other instances.

Then, analogy and common sense teach us that induration,

as a symptom of the chancre, may be wanting, just as any sign may be absent in any disease, without the chancre being thereby modified in its nature and essence.

In truth, it is not the induration which constitutes the chancre, any more than it is the crepitation which constitutes the fracture. The induration does not give to the chancre its syphilitic quality; it is the syphilitic essence of the chancre which endows it with its characteristic induration. In a word, the chancre is not syphilitic because it is indurated, but, on the contrary, it is indurated because it is syphilitic; and it is syphilitic without induration, even as it may lack any other of its constant symptoms. This is so simple that it would scarcely seem possible that such a question should cause great discussion; but still it is one of the points in syphilography which have given rise to the most lively controversies, and you would scarcely believe that by means of a mere syllogism, I would almost say, *a play upon words*, observers have obscured so simple a question. As, by general admission, the induration of chancres may be wanting in certain cases, some observers, strengthening themselves by this argument, have reasoned as follows: "Acquired syphilis can follow a non-indurated chancre. Now, a non-indurated chancre is a soft chancre, therefore the soft chancre can be the forerunner of syphilis."

And upon these premises they have added that,

"Since the soft chancre is sometimes, as well as the hard chancre, the forerunner of syphilis, it is evident that the former is identical in nature with the latter. At least it only differs in one symptom, its induration, and is susceptible of the same consequences, and is derived from the same virus. Then it is useless to describe these two chancres as two diseases foreign to one another, as they are simply varied expressions of one and the same disease—syphilis."

It is apparent to what doctrinal conclusions such arguments tend, but if the reasoning be closely followed, its errors are readily discovered. The whole series of deductions has its foundation in the assertion that a non-indurated chancre is a soft chancre, and as this portion of the syllogism is erroneous, all the support of the subsequent propositions falls immediately. Now it is only by a strange perversion of language that things so radically different as the hard and the soft chancre can be assimilated.

I do not deny that in popular language the two words, *non indurated* and *soft*, as applied to chancres, represent to the mind the same idea; but clinical teaching, also, has its language, its words, and terms, to which, good or bad, a certain

conventional meaning is attached. Now, in clinical language, this name of soft chancre is not applied to every chancre, the base of which is devoid of induration, but to a particular species of chancre, a special disease characterized by a group of symptoms and signs which properly belong to it. For us physicians, it is not only a chancre of which the base is soft, but one endowed with peculiar attributes, constituting a pathological species of a given class. If a chancre of a different variety should present a soft base, it would not follow from that, that it was a soft chancre, nor would it be allowable to class it as such, for fear of falling into a deplorable cacology. In spite of its soft base, it will always be a chancre of a different variety, even as a pneumonia will always be a pneumonia, in spite of the absence of one of its most constant symptoms or the presence of an unusual symptom. Reasoning thus, a syphilitic chancre which does not present its usual indurated base cannot be called a soft chancre; it is merely a syphilitic chancre, having a soft base. To class it as a soft chancre, simply because it has a supple base, is, on the one hand, to forget that a syphilitic chancre has other characters than those of its base, and, on the other hand, to be ignorant of the fact that the soft chancre can accidentally present a more or less resistant base. To say that a non-indurated chancre is simply a soft chancre, is to be guilty of a strange abuse of clinical language, of playing upon words, and by means of an ambiguity of expression of confounding at will different things, and of introducing into science, under the guise of a captious synonymy, a confusion greatly to be deplored.

It being understood that a non-indurated chancre is not identical with a soft chancre, what becomes of the deductions which, it has been thought, can be drawn from the factitious resemblance of these two morbid species? Naturally and forcibly, they share the fate of conclusions which are based upon syllogisms with false premises. They fall because they have no foundation. There is no reason for their existence. By the same argument it was maintained that there existed a unique virus, capable of different morbid manifestations, but of this absolutely nothing remains. As we have seen that non-indurated chancre and soft chancre are essentially different lesions, there can be no inductive proof, drawn from the particular condition of resistance or suppleness of its base, for or against the identity of nature of the two lesions. This is what simple common sense and clinical observation teach.

All this, however, is more important from a doctrinal than from a practical stand-point, as you will very rarely meet this peculiar difficulty; for in man, chancreous induration will be

readily appreciated, if not always, at least in the great majority of cases; and in woman this valuable diagnostic sign will only be wanting in a very limited number of cases, if it is only sought for attentively and studiously. Before closing, I will present numerical proof.

I take indiscriminately one hundred cases of syphilitic chancres in women, observed in this hospital. Out of this number, how many times have I and my students been able to detect induration and record it in our notes, and, on the contrary, how many times has it been absent? Among these one hundred cases, conscientiously observed, and taken at random, as being the first which came to hand, I find that in eighty-seven, the induration existed in a very manifest manner, sufficiently so for a positive diagnosis; on the contrary, it was absent in thirteen cases. The figures are significant—eighty-seven against thirteen. But let us examine further. Out of the thirteen exceptional cases, I find that, in eight of them, the induration was not observed, because the base was inexplorable, and could not be seized between the fingers. In these eight cases the chancres were situated upon the cervix uteri, the anus, and the entrance of the vagina, localities where, as has already been said, the base of the chancre is with the greatest difficulty examined. Now, a sign which the observer has not the power of finding, cannot be considered as absent; so in strict justice, we must deduct these eight cases: then there remain five cases in which induration was not observed. These five cases are divided as follows: in four the induration was so slight as to remain doubtful; in one there was not the slightest evidence of the resistance of its base.

Such figures need no commentary, and I think that the most rigorous clinical observation, supported by the results of experimentation, warrant me in establishing, as being well demonstrated and indisputable, the following proposition: *Without being absolutely constant, the induration of the syphilitic chancre in women is so generally and commonly present that we may consider those cases exceptional in which it is absent.*

A SIMPLIFICATION OF HEBRA'S ANATOMO-PATHOLOGICAL CLASSIFICATION OF THE DISEASES OF THE SKIN.

BY DR. J. NEUMANN OF VIENNA.

TRANSLATED FROM THE "ARCHIV. FÜR DERMATOLOGIE UND SYPHILIS,"
BY DR. BERNHARD GRUNHUT.

A CONCISE classification of diseases of the skin is of such value to the student that its merits cannot be overrated. This is especially the case, where a system is founded, not upon a mathematical basis, but rather on close clinical observation of morbid phenomena. Generally speaking, classifications are of the greatest service to the student, and that one will be found the best which places like and unlike lesions in their appropriate groups. If we glance over the classifications of Alibert, Duchesne-Duparc, Wilson, Chausit, Hardy, Bärensprung, Buchanan, Hebra, and other dermatologists, we find different names for the same diseases. Hebra's system, which, like all his other productions, has had the greatest number of followers, is well known to be founded upon the division of Rokitansky.

The first class, Hyperæmia and Anæmia, we find only in Bärensprung's third class, viz., Derangements of Nutrition.

The third class, Anomalies of the organs of Secretion we find also as a separate division in Wilson and Bärensprung.

The fourth class, Exudations, we find in other authors under the name of Inflammations (Alibert's Dermatoses Eczematous and Exanthematous)—Wilson, Hardy, and others.

The fifth class, Hemorrhages, is styled by Wilson, Anomalies of the Blood-vessels (Nævus, purpura), and Chausit, Buchanan, Bärensprung, and others retain the name of Hemorrhages.

The class of Hypertrophies is also found in Duchesne-Duparc and Bärensprung.

The class of Atrophies is found in no other author.

Under the titles of Homoplasia and Heteroplasia we only find the names of the different diseases.

The class of Ulceration is only found in Plenck and Bärensprung, while that of the Parasitic Diseases only in Chausit and Hardy.

As may be seen by this brief review many of Hebra's divisions are to be found in other authors.

Bearing in mind my introductory remarks I shall take the liberty in the following classification, which should be looked upon as a simplification of Hebra's, of omitting some classes (Hyperæmia, Anæmia, Ulcerations), and of condensing other groups. I have endeavored, in this attempt, to give full weight to modern histological research, although histology must not be considered as its exclusive stand-point, for I was compelled to recognize etiology and clinical appearances as bases of division. For instance, prurigo, lichen, and psoriasis are still found in this classification, under the head of Inflammation, whereas they perhaps would be more appropriately placed under that of Hypertrophies and Neoplasms.

The following is the system which we would offer :—

CLASS I.—*Anomalies of Secretion.*

- A. Of the Sebaceous Follicles.
 - a. Increase of Secretion : Seborrhœa.
 - b. Retention of Sebum : Comedo, milium, vitiligoidea, molluscum contagiosum, wens, and concretions.
 - c. Diminution of Secretion : Xeroderma.
- B. Anomalies of the Secretion of the Sweat-Glands.
 - Hyperidrosis, anidrosis, bromidrosis, and chromidrosis.

CLASS II.—*Inflammations.*

- A. Contagious.
 - a. Having a Typical Acute Course: 1. Small-pox. 2. Scarlet fever. 3. Measles.
 - b. Infection by Animal Poisons: Malignant pustule, dissection wounds, snake-bites, glanders.
 - c. Diphtheritic inflammation.
- B. Non-contagious Inflammations.
 - a. *Erythematous*: Erythema papulatum, gyratum, annulare, iris, nodosum, urticans; vaccinal roseola; urticaria; lichen urticatus; pellagra; erysipelatos.
 - b. *Phlegmonous*: Furuncle, anthrax, pseudo-erysipelas.
 - c. *Vesicular*: Herpes labialis, præputialis, zoster, iris, circinatus; sudamina; eczema.
 - d. *Bullous*: Pemphigus.
 - e. *Pustular*: Acne, acne rosacea, sycosis, impetigo, ecthyma.

f. Squamous: Psoriasis, pityriasis rubra.

g. Papular: Prurigo, lichen scrophulosorum, lichen ruber.

C. Traumatic Inflammations.

a. Due to mechanical causes: Traumatic erythema, excoriations.

b. Due to chemical causes: Cauterization, vesication.

c. Due to caloric: Burns, frost-bite.

CLASS III.—*Hemorrhages.*

Purpura simplex, rheumatic, papular, scorbutic ecchymotic; morbus maculosus Werlhofii.

CLASS IV.—*Hypertrophies.*

A. Due to epidermal proliferation.

Lichen pilaris, tylooma, clavus, ichthyosis, verruca, cornu cutaneum, hypertrophy of the hair (polytrichia, trichauxe), hypertrophy of the nails (onychogryphosis).

B. Due to the proliferation of the connective tissue elements.

1. Circumscribed: Acuminated condylomata, frambæsia.

2. Diffused: Elephantiasis Arabum, scleroderma.

CLASS V.—*Atrophies.*

Senile atrophy, alopecia areata, atrophia cutis, linear atrophy from pregnancy, atrophy due to pre-existent dermatitis, cicatrices, atrophy of the hair (alopecia).

CLASS VI.—*Neoplasms.*

a. Diffused Deposits: Lupus, syphilis, elephantiasis Græcorum.

b. Tumors: Fibroma molluscum, papillary hypertrophies, keloid, angioma, lipoma, adenoma, sarcoma, carcinoma.

CLASS VII.—*Anomalies of Pigmentation.*

A. Absence of Pigment: Albinismus, vitiligo (leucopathia acquisita).

B. Excess of Pigment: Nævus, ophelis, lentigo, chloasma, melasma, Addison's disease, argyria, etc.

CLASS VIII.—*Neuroses.*

Derangement of Sensation and of Locomotion, Angioneuroses.

CLASS IX.—*Parasites.*

A. Animal Parasites.

1. Having their habitat in the skin : *Acarus scabei*, *acarus folliculorum*, *filaria medinensis*, *pulex penetrans*, *ixodes ricinus*.
2. Living temporarily upon the skin : *Cimex lectularius*, *culex pipiens*, *leptus autumnalis*, *pediculus pubis*, *pediculus capitis*, *pediculus vestimenti*.

B. Vegetable Parasites.

Favus, *herpes tonsurans*, *pityriasis versicolor*, *eczema marginatum*, *onychomycosis*, *sycosis parasitica*.

TWO CASES OF SYPHILITIC DISEASE OF BRAIN.

BY DR. A. GAY, OF KASAN.

TRANSLATED FROM THE "ARCHIV FÜR DERMATOLOGIE UND SYPHILIS,"
BY DR. FRANK P. FOSTER.

DURING the past year I have had the opportunity of observing two cases of syphilitic disease of the brain, which, on account of the rarity of such affections, and because both of these cases presented various and intrinsically interesting clinical features, I will here briefly recount :—

CASE I.—Anna C., a soldier's wife, twenty-one years old, of medium build, entered the infirmary September 29, 1868. She stated that about a year previously she had had an ulcer of the vulva, which soon healed, but the character of which she could not describe. Two months afterwards a rash appeared, and subsided without treatment. But six weeks previously she had had a rash, which, from her various statements, appears to have been one of the earlier ones ; at the same time there was a humming noise in the ears. On examining the pudenda, no mark of a previous ulcer was found ; the skin of the trunk and extremities showed a papular exanthem, more copious on the lower than on the upper limbs ; the lymphatic glands of the neck, of the axillæ, and of the inguinal folds were markedly swollen and indurated ; the mucous membrane of the throat was injected and swollen, and on the posterior wall there was observed an ulcerated patch as large as a *kreutzer*, with a dirty-looking surface. The

patient complained of headache and roaring in the ears. She was ordered $\frac{1}{10}$ grain of corrosive sublimate, in pills, daily.

October 19th.—Dose of the sublimate increased to $\frac{1}{8}$ grain.

October 23d.—Headache more severe. Ordered 15 grains of iodide of potassium daily.

November 2d.—On account of severe colic, the iodide of potassium and the pills of corrosive chloride of mercury are suspended.

November 6th.—Headache *in statu quo*. Medicines to be resumed.

November 19th.—Headache still more severe.

November 29th.—Patient states that the pain is especially severe in the right half of the head.

December 1st.—Pills and iodide suspended, and inunction with mercurial ointment ordered.

December 5th.—Headache *in statu quo*; sleeplessness.

December 7th.—This morning she suddenly lost the power of speech, accompanied with paresis of the extremities of the left half of the body and of the left facial nerve. Sensibility of the paralyzed parts normal; sight unaffected. With all these symptoms she did not lose consciousness. Inunctions continued.

December 8th.—Speech is gradually returning; enunciation indistinct; answers questions rationally, but after a long pause.

December 10th.—Occasional cramps in the left hand.

December 12th.—Cramps have ceased; headache less severe.

December 14th.—Paresis has returned.

December 30th.—Patient suddenly lost consciousness, which was regained after two hours. She cannot speak a word. Paresis *in statu quo*.

January 11, 1869.—The headache is considerably diminished; the partial paralysis of the extremities has disappeared; the derangement of the facial nerve is only slightly noticeable; only a slight weakness of the affected limbs remains, and she is able to conduct the inunction herself.

January 12th.—Headache has entirely disappeared.

March 17th.—She was dismissed, the symptoms having entirely yielded.

In this case, the early appearance of brain symptoms, together with the absence of syphilitic changes in the bones, would lead to the opinion that the brain substance itself was affected. As regards the nature of the brain lesion, this can of course be only approximately stated. The course of the disease, and the results of recorded cases, render it extremely probable that in this case there was an exudative process within the brain. The result renders it improbable that there was inflammatory trouble.

CASE II.—Johann P., a retired non-commissioned officer, forty-four years of age, of medium build, entered the infirmary December 28, 1868. Nothing positive could be ascertained from the patient in regard to previous illnesses; it was only learned that about a month previously he had had a papular exanthem, especially on the face, from which it had spread to the hairy scalp. On examination, besides the exanthem, there was found a tumidity of the glans penis, with phymosis; no induration could be felt through the prepuce. The lymphatic glands of the neck, of the axillæ, and of the groins were enlarged and indurated, and the mucous membrane of the throat red and swollen. Ordered $\frac{1}{10}$ grain of corrosive chloride of mercury daily.

January 8, 1869.—Dose of mercury increased to $\frac{1}{2}$ grain.

February 25th.—Exanthem is disappearing.

March 4th.—Fever, heat, and headache. Pills suspended, and quinine ordered.

March 20th.—Febrile movement has subsided; a pustular exanthem is observed on the face and hairy scalp; complains of constant headache, and weakness of the left upper extremity. Ordered inunction with mercurial ointment.

March 26th.—Paralysis of left facial nerve, and paresis of left upper and lower limbs.

April 4th.—Return of the exanthem, together with paresis of the limbs.

April 10th.—Headache has entirely disappeared.

April 15th.—Complains of severe palpitation of the heart. Ordered a scruple of sulphate of quinine daily.

April 16th.—Palpitation less severe.

April 18th.—Palpitation has entirely disappeared.

April 22d.—Paresis of the limbs has subsided. Face somewhat drawn to the right side.

May 3d.—The exanthem has entirely disappeared, and patient leaves the infirmary with very inconsiderable distortion of the face.

If we compare the foregoing portion of our patient's history with that of the first case, we may conclude from their resemblance to each other that in this case also we were dealing with an exudative form of brain lesion; but the subsequent features of the case, when the patient returned to the infirmary, lead us to change our opinion. Soon after leaving the infirmary, the patient was again affected with severe palpitation, with great embarrassment of respiration, which symptoms continued to increase; there was also œdema of the lower limbs, and anasarca. On the 31st of May, 1869, he was obliged to return to the infirmary, at which time he was in the following condition:—

Patient excessively anæmic; skin clear; cellular tissue markedly œdematous; face drawn to the right side (*par. nerv. fac. sin.*). Right upper eyelid droops; patient cannot raise it; consequently the eye is only half-opened (*paresis lev. palp. sup.*). The other muscles of the eye act normally; sight and hearing unaffected; speech laborious, the words being indistinctly uttered; on protruding the tongue, it is drawn to the right (*paresis nerv. hypogloss. sin.*). The left upper limb is partially paralyzed; lower limb normal; patient complains only of weakness in the left foot. No headache; lymphatic glands of the neck, of the axillæ, and of the groins enlarged and indurated; mucous membrane of the throat considerably reddened and swollen; slight rattling in the lungs; percussion detects nothing abnormal. Cardiac dulness does not exceed the normal extent, and its position is only slightly higher than natural; heart-sounds feeble, but clear; number of beats in a minute from 120 to 150. Examination of the abdomen showed moderate obstructive ascites, and it was observed that the hepatic dulness was markedly enlarged, extending from the nipple-line in the fourth intercostal space four or five centimètres under the curve of the ribs. Left lobe of the liver enlarged, its dulness extending far beyond the median line. Spleen slightly enlarged.

The phenomena above recited point unerringly to syphilitic disease of the brain, but there remains the nice question as to the nature of this disease. This question cannot be definitely answered. The above conjecture of an exudative form of brain lesion was contradicted by the features of the disease, which were brought to light on the patient's second admission to the infirmary. The gradual development of the symptoms, the successive invasion of various organs by the paralysis, point to syphiloma of the brain; but, opposed to it are, the early period of the syphilis, the absence of any affection of the bones, and of syphilitic gumma. Our history of the case affords insufficient data for us to receive it as an example of the third form of syphilitic brain disease—inflammation with softening. A positive diagnosis in the case is, then, impossible. At most, by excluding exudative lesion, we may infer the existence of a tumor, or of softening of the brain substance. No changes were found in the lungs. From the simultaneous development of the dyspnoea and the palpitation, likewise, we may easily attribute both symptoms to the brain lesion.

On account of the palpitation, tincture of digitalis was ordered.

June 3d.—Pulse 80; dyspnoea has ceased. Ordered a dram of iodide of potassium daily.

June 10th.—Return of anasarca.

June 14th.—Attacked in the night with palpitation and dyspnoea, which lasted until morning.

June 25th.—Another attack of palpitation and dyspnoea. Paresis of eye-lid slight.

June 26th.—Complains of loss of memory; forgets, for instance, the words spoken just previously, also forgets where he has laid his clothes. Answers questions rationally, but after an interval; speech indistinct.

June 27th.—Albumen in the urine. Iodide of potassium suspended, and iodide of iron ordered.

July 1st.—Attacks of dyspnoea and palpitation mostly occur during the night. From evening until 1 o'clock, A. M., they increase, and after that time they moderate, so that the patient feels notably better in the morning.

July 4th.—Ptosis considerably less.

July 5th.—Became suddenly comatose. Died at 8:30, P. M., without special additional symptoms.

*Autopsy.*¹—Calvaria oval, moderately thick; diploe slightly developed, its vessels containing little blood. Dura mater lax, anæmic on its left half; at a distance of four centimètres from, and a little in front of, the middle of the longitudinal sinus, a convolution of Pacchionian granulations, which are pale, soft, semi-transparent, and of the size of peas. Opposite them, upon the left parietal bone, was an indentation of the same size. At this point the meninges were adherent to each other, and to the brain. Pia mater œdematous in spots, slightly glistening.

At the distance of three and a half or four centimètres outwards from

¹ Section and microscopic examination conducted by Prof. Petroff

the centre of the right optic thalamus, the white brain substance is softened to the depth of a centimètre and a half. In this situation there are cavities of the circumference of a pea. Directly in front of this, at a distance of five centimètres, is a spot of precisely similar character, of about the circumference of a hazel-nut, only the tissue is not so soft, and the loss of substance (cavities) of less extent. The tissue of the inner layer of the right optic thalamus, for a space as large as a hazel-nut, is very soft and somewhat diffuent. The white substance shows a few points of blood; the gray substance is pale, and not sharply defined from the white substance. The softened portion shows under the microscope no considerable amount of hyperæmia. The parietal tissue of the cavities is easily broken down, and resolves itself into its elements on attempting to make a section, so that any pathological change in the development or arrangement of the histological elements cannot be perceived. The outline of the cavities is uneven, and gives forth variously-formed filaments, surrounded by a finely-granular material.

On opening the thorax, the lungs do not collapse; behind, they are adherent to the pleura costalis. The heart is enlarged—length, about thirteen centimètres; breadth, eleven centimètres; on its surface are a few tendinous spots; the valves of the aorta, of the pulmonary artery, and of the right side of the heart are normal; on the free border of the mitral are a few soft, pale vegetations, of the size of a small pea, and under. The muscular structure of the left side of the heart is of a dusky-red hue, of firm consistence, and the walls thicker than natural.

The left lung is of firm consistence; scarcely crepitates at all on section; cut surface of a pale-brown color, and exuding a little blood. Bronchial mucous membrane injected. The apex of the right lung shows several dense cicatricial retracted spots, rendering the surface uneven from the depressions. In the parenchyma is a cavity as large as a walnut, filled with a thick grumous substance.

The liver is enlarged, especially increased in thickness; its parenchyma is of firm consistence. On section, the centres of the hepatic lobules appear rich in blood. In the gall-bladder is a considerable quantity of thick mucous bile. The blood-vessels, especially the intra-lobular vessels, are extremely distended, so that the hepatic cells are compressed and changed into a fine irregular net-work of an orange-yellow color, in the meshes of which red blood-corpuscles are packed.

The spleen is somewhat enlarged, firm; its capsule strongly adherent. cut surface smooth. No transformation detected under the microscope.

Kidneys of the natural size; section shows marked injection of the pyramids and cortical substance. The epithelial cells of the convoluted uriniferous tubules are thickly strewn with fine golden granules, with which the nuclei also are abundantly covered, so that even the boundaries between the individual cells are obliterated. In many portions the cells are wholly atrophied.

Epitome of Current Literature.

Syphilitic Iritis with Interstitial Keratitis.—Dr. Demarbaix, *Chef de Clinique* to M. Desmarres, reports a case of this interesting complication. The patient, aged thirty-eight years, had slight photophobia and peri-corneal redness, with some lachrymation and opacity in the anterior chamber and multiple posterior synechiæ. Upon the right side there was an interstitial keratitis of a triangular form, the base of which was below, and the apex impinged upon the pupillary field. Besides these lesions, there were other symptoms of far advanced syphilis, such as desquamating patches and deep ulceration of the throat. The case was diagnosticated as one of double *malign* syphilitic iritis, which occurs later in the disease than the lesion M. Desmarres terms *benign* syphilitic iritis, which is a symptom of the early stage of the disease. M. Desmarres thinks that the usual rule of development of the lesions of syphilis first in the superficial layers of the derma, and then later on deeper in its structures is followed in the ocular tissues, consequently that there are two forms of syphilitic iritis, the one which appears with other early manifestations, such as the exanthems and *plaques muqueuses*, in which the iris alone is involved, leaving uninjured the ciliary body, the choroid and sclerotic, and which, from its amenability to cure, M. Desmarres calls *benign* syphilitic iritis; the other form occurs coincidently with such profound lesions as gummy deposits and deep ulcerations. In this variety the morbid process begins in the ciliary circle, and the iris becomes secondarily involved, the sclerotic also may undergo change, become thinned, and a hernia of the intra-ocular structures take place; the cornea is also sometimes affected as seen in the case reported. In the latter form the whole structure of the iris is involved, and as it is rebellious to treatment, the prognosis is doubtful, or even grave, M. Desmarres calls it *malign* syphilitic iritis. The latter lesion is more properly speaking, a syphilitic cyclitis, whereas the former is a true iritis. The same or a similar lesion of the ciliary body is noticed in scrofulous subjects and those who have lived under unfavorable hygienic conditions.—*Gazette des Hôpitaux*, July 2, 1870.

Acute Syphilitic Myelitis.—Dr. Humbert Mollière, referring to the want of a precise knowledge of this lesion, and to the doubts entertained by some observers as to its occurrence, reports a somewhat hypothetical case.

A man aged forty-one, having had an indurated chancre and the secondary symptoms of syphilis fifteen years previously, was admitted to the Hôpital de la Croix-Rousse of Lyons on July 3, 1869, for very severe tertiary lesions. For a few days previously he had had an acute bronchitis and intolerable nocturnal pain, and besides a pustulo-crustaceous syphilitic epididymitis of the left side; yet he had not lost flesh. He was treated with specifics. On the 7th of July he was seized with retention of urine, then in the following days he suffered from slight fever, and experienced weakness in the lower limbs, painful hemorrhoids, prolapsus recti, and an obstinate constipation with abdominal pains completed his group of symptoms. On the 17th, while in a hip-bath, he had an involuntary and painful escape of fæces and urine, followed by exhaustion. Suddenly an intense fever set in, and he became delirious and had subsultus tendinum. He took quinine and iodide of potassium. Paraplegia was noticed in a day or two, which was accompanied with marked hyperæsthesia, the patient experiencing pain even on movement of the limbs. The pulse was 128 and small, the temperature was 38·6°, and the urine contained great quantities of pus. He died comatose, upon the 18th, having had a few lucid moments. The autopsy revealed an intense congestion of the spinal meninges, and the portion of the cord including the lumbar enlargement and cauda equina was markedly hyperæmic; the posterior median artery and larger vessels being gorged with blood. One large vessel much more congested than the rest was seen among the filaments of the cauda equina upon the left side, and it was noticed that during life the corresponding limb was most painful, for, even when delirious, pain was experienced by the patient if the limb was moved. The white and gray substances were equally hyperæmic. The viscera had not undergone amyloid degeneration. The lesions found in the testicle and epididymis were not those peculiar to syphilis.

From the coincidence of this acute myelitis with well-marked tertiary lesions, it is supposed to be of syphilitic origin.—*Annales de Dermatologie et de Syphiligraphie, Deuxième Année, No. 4.*

Syphilitic Affection of the Third Nerve with Mydriasis and Ptosis.—Mr. Withington, of the Bristol General Hos-

pital, reports an interesting case of this lesion. The patient, aged 28, having had well-marked syphilitic symptoms, applied for admission complaining of dimness of vision and vertigo. The right pupil was largely dilated and immovable and the upper eyelid drooped. On raising the lid, the eye was seen to be directed outward, through the unbalanced action of the external rectus. He could not move the eyeball upwards or inwards, and on being told to look downwards, the superior oblique muscle through the sixth nerve acted alone, and produced a distinct inward rotation around the visual axis. There was diplopia and amblyopia. In a few days the ptosis became complete. The pupil was extremely dilated and the cornea hardly reached the middle of the eyelid when an effort was made to look inward. He was soon after seized with right hemiplegia, the arm being more paralyzed than the leg. The cheek puffed out, and the tongue protruded to the right, he whistled only with the left half of the mouth, and the right nostril was diminished in calibre. The uvula was directed towards the right side and there was dysphagia and imperfect articulation. As is common in paralysis of the third nerve he had complete paralysis of accommodation, but as the sphincter pupillæ has regained its power, this becomes less. There was hypermetropia of the affected eye, the furthest point of vision was twenty-six inches. As he could see quite distinctly through a small hole cut in blackened paper, it was thought that he had no retinal lesion. It is probable that his disturbances of vision were due to anomalies of refraction and accommodation resulting from paralysis of the ciliary muscle and of the iris. Under the use of the iodide of potassium and iodide of mercury he improved in all his symptoms.—*Lancet*, April 23, 1870.

Syphilitic Paralysis of the Seventh Nerve.—Mr. J. R. Lane has under his care at the Female Lock Hospital a woman who had the initial lesion of syphilis upon the lip, which was followed by secondary symptoms, for which she took mercury. About eight months after the appearance of the chancre, having in the meantime had two crops of eruption and having suffered from rheumatoid pains, her face was observed to be drawn to the left side, and she was unable to close the right eye, and she had severe pain in the head which was worse at night, but could not be localized. Under the use of iodide of potassium internally and mustard poultices to the back of the neck she was somewhat improved and the pain became localized to the right mastoid process, which was tender upon pressure. The pain also extended to the back of the neck. There was no alteration of sensation in the affected parts. In eighteen days the paralysis

had disappeared and no other syphilitic symptoms were observed.—*Lancet*, July 9, 1870.

Mucous Patches of the Vulva and Anus.—Dr. Soresina, physician to the Syphilicôme of Milan, has practically examined into the merits of the views of Professor Thiry of Brussels upon this subject.

The views of Professor Thiry may be stated as follows:—

1. That mucous tubercles of the vulva and anus are simple lesions, caused by uncleanness, abuse of coitus, and that they will yield to a strictly local treatment.

2. That they are not virulent or contagious when they are not ulcerated.

3. That constitutional syphilis is only observed in those cases in which the ulceration has been followed by induration.

Impressed with the importance of the scientific, therapeutic, and medico-legal bearing of these assertions; Dr. Soresina carefully studied the subject for nineteen months. He makes the following statements before presenting his results:—

1. That his observations relate exclusively to prostitutes treated at the Syphilicôme of Milan, who were affected with mucous patches of the genital parts and the margin of the anus, and that it was necessary not to confound them with similar lesions sometimes observed upon the nipples of nurses who have suckled syphilitic children.

2. That in order to remove any idea as to the influence of mercury in the success of the treatment he had even renounced yellow wash, and had used exclusively lotions of cold water and mild pencillings with nitrate of silver when the patches had ulcerated.

3. That not being content with observing his patients merely for a few weeks, he had continued his observations for several months after the disappearance of the lesions, in order to be positive that they were not followed by constitutional syphilis.

Dr. Soresina's observations were made during the interval of time between the months of June, 1863, and December, 1864, and included twenty-six cases. His results he summarizes as follows:

In twenty-two cases out of the twenty-six, without mercurials, and with merely simple lotions, cleanliness, and gentle pencillings with the nitrate of silver, the mucous tubercles disappeared in a very short space of time. And that only in five cases had secondary syphilitic symptoms been developed, and the patients had been kept from six to twelve months afterwards under careful surveillance.

Soresina's observations do not confirm the proposition of

Thiry, that when the tubercles become ulcerated they were contagious, and that when indurated they had the power of transmitting constitutional syphilis, for, out of his five cases which were followed by syphilis, in four the tubercles were ulcerated, while in the fifth they were perfectly dry. He, however, explains this discrepance as follows :—

1. That in order to explain the simultaneous or consecutive development of syphilis in some cases and its absence in others we must admit two varieties of mucous patch, the one simple, the other syphilitic.

2. That all mucous tubercles of the vulva and anus, both simple and specific, are originally simple lesions, produced by a common cause, and that just as a simple wound or any traumatic lesion may in a syphilitic subject assume a syphilitic character, so in the same manner vegetations and mucous patches developed in a subject already contaminated with syphilis may assume the characters of that diathesis.

Thus he thinks that their power of contagion and the fact of their being followed by secondary symptoms do not depend upon the tubercle becoming either ulcerated or indurated. Such then are the views of Dr. Soresina upon this subject and they are very similar to those of Thiry :—*That mucous patches developed upon the genito-anal region of prostitutes are usually simple lesions and wholly independent of constitutional syphilis.*—*Annales de Dermatologie et de Syphiligraphie, Deuxième Année.*

The Proportion of Abortions in Syphilitic Women.—Dr. Weber, of St. Petersburg, having had for four years the charge of the venereal wards, took the opportunity to examine how far syphilis acts upon the fœtus.

Forty pregnant women, suffering from syphilis were admitted during this period. They were all treated with mercury, and then with mercury and iodide of potassium. Topical applications were made regardless of pregnancy. Of these forty women, thirty-three left the hospital without any disturbance of the process of gestation, and seven were confined in the institution. Of these three went to term and had healthy children; the four others were prematurely confined, one in the sixth month, two in the seventh, and one in the eighth. The children presented no signs of syphilis; but they died within a few days of weakness.

Hence out of forty syphilitic pregnant women, confinement was premature in only four, and as two in three born had intercurrent disease, we have actually only two suffering from constitutional syphilis. [It must be remembered there are no data

of the thirty-three who went out]. Though it may be urged that treatment modified the course of events, it seems clear to Dr. Weber that syphilis only exerts a doubtful (*sic*) influence upon pregnancy.

Details are then given of intercurrent diseases in the parturient state: Acute diseases, 79; premature labor, 29—viz.: 36.5 per cent.; death of mothers, 13—viz., 44.8 per cent.; death of children, 26—viz., 89.6 per cent. Chronic diseases, 6; premature labor, 3; mothers all died; of the children, only 1. The conclusions are that of all affections syphilis (*sic*) has the least amount of influence upon the course of gestation.—*Lancet*, January 1, 1870.

Ulceration of Palate in Young Subjects.—Mr. Jonathan Hutchinson, of the London Hospital, had under his care, in November last, a healthy-looking girl, eleven years of age, for ulceration at the back of mouth, which resulted in destruction of the uvula and the adjacent soft parts, and perforation of the soft palate. Mr. Hutchinson, in his lecture to the students, stated that as this lesion in the adult generally indicates tertiary syphilis, its existence in the young subject suggested the idea of hereditary syphilis; but it has been observed that destruction of the palate at an early age is very rarely if ever associated with signs of inherited syphilis. In the present patient there was neither deformity of the teeth, nor keratitis, nor could periosteal thickening be detected. If, as we have good reason for believing, early ulceration be due to hereditary syphilis, then this lesion characterizes a group of cases quite distinct from that in which the ordinary symptoms of inherited disease, such as pegged teeth and keratitis, are presented. The most effective treatment of sloughing of the soft palate in young patients is the local application of nitric acid or the acid nitrate of mercury.—*Lancet*, January 22, 1870.

Duration of the Power of Syphilitic Contagion.—Dr. Drysdale relates the case of a child three and a half months old, upon which, according to the statement of the mother, a papular *café-au-lait*-colored eruption, which covered the child from head to foot, had existed for two months; the child was born even hearty. Its mother, aged 37, had been married twelve years; at the commencement of married life, she had sore throat, eruptions, and fall of hair, and, having been treated, had since been quite well; her husband had likewise been well. Her first child was born two years after marriage, and died at the age of three months with an eruption similar to that on present child. The next child, which followed in a

year, was still-born, while the next lived seven months, and had no eruption. The next child, now four and a half years old, has interstitial keratitis, and a portion of the left *ala nasi* is destroyed by a syphilitic ulcer. It is remarked that, in consideration of such cases, it is impossible to lay down any general law as to the limits of the time when syphilitic persons can procreate healthy children.—*Medical Times and Gazette*.

Dystochia from Syphilitic Induration of Cervix.—Dr. Putegnat mentions five cases, in which large indurated ulcerations, caused difficult parturition. All the confinements were premature. The first required incision of os and version; but the mother died after giving birth to a child which had died some time previously. In the other four cases the children died, but the mother recovered. The parts relaxed sufficiently for the passage of the children.—*Lancet*, April 16, 1870.

Gangrene of the Penis.—M. Demarquay calls attention to the fact that until now no special treatise has been devoted to this subject. He thinks that it is not a rare lesion, and he has collected from various sources the details of twenty-five cases.

The seat of the lesion is not constant, the prepuce being the portion most frequently attacked, but the sheath of the penis even as far as the integument of its root, and beyond, is sometimes the seat of the morbid action. In other cases the deeper portions of the organ, the cavernous and spongy, are diseased and the skin is only in places perforated with fistulae.

The dry variety of gangrene is the most frequent, though the moist variety is observed; and, while total gangrene is rare, extensive ravages are often made in the penis.

The causes are rather local than general, and among the latter may be mentioned the predisposing and exciting; among the former, age and constitution have an important place.

While gangrene is mostly observed in young men who are exposed to the various venereal contagions, it is also observed in infants after the epidemic exanthemata, and in old men due to local causes.

The lymphatic flabby constitution is especially predisposed to this trouble; but it is also observed in robust persons.

The exciting causes are fevers and poisonings.

Cases of gangrene of the penis have been observed to occur during attacks of small-pox, typhoid fever, malign erysipelas, and scarlet fever, and Rostan relates a certain case of confluent small-pox, in which, in consequence of a pustule appearing upon

a tight prepuce this accident occurred. Gangrene of the penis rarely results from simple erysipelas; it is generally in cases of a pre-existing wound of the penis, or of a co-existing phlegmon, or following operations in the vicinity of the penis—the perinæum for example—that this complication manifests itself. Ergot, it is thought, might produce the lesion, as it does in the female vaginal mucous membrane, and glanders has been known to cause it. But the principal causes are local, among which phimosis plays an active part, in retaining decayed secretions, and compressing ulcers when they exist beneath it. Circumcision has been known to be followed by gangrene of the penis. Paraphimosis may also cause it; but it is generally only of the constricted parts. Traumatic causes, such as rings or ligatures around the penis, calculi arrested in the urethra, or foreign bodies inserted into that canal, and wounds of the organ have been known to produce this condition. Forceful catheterism and retention of sounds in the urethra are said to have produced it, but it is generally in the case of old men. The wounds of the penis which are productive of gangrene are of two varieties, the one the result of surgical operation and bruises, the other of chancres which take on destructive action. The accident is particularly liable to follow contused wounds, and twisting of the penis while erect has likewise caused it. But the active corollary of all these conditions is inflammation, which may commence and terminate with the gangrene. The inflammatory conditions are balanoposthitis, phlebitis of the dorsal vein, and penitis. Gangrene rarely follows balanoposthitis, and then is generally confined to the prepuce. Phlebitis of the dorsal vein has been known to follow the abortive treatment of gonorrhœa. During typhoid fever the lesion has been known to take place, and as a consequence of extravasation of urine behind a tight stricture, or in cases of false passage, the urine has acted upon the tissues, causing extensive gangrene. In certain congenital malformations of the urethra, epispadias and hypospadias, patients sometimes use catheters, and tear or chafe the urethra, and in that way produce gangrene; therefore operative procedures should be undertaken to remedy the faulty condition of the organ.

The symptoms of gangrene of the penis are, first, general constitutional disturbance, followed by swelling and œdema of the organ, and then very soon blebs form. The color of the organ becomes livid, sensibility diminishes, pain ceases, and the temperature falls; these symptoms increase with the progress of the disease. The mass assumes a black color, may be either soft or hard, and at its periphery a sinus or line of demarcation forms.

In from fifteen to twenty days, generally about ten, coincidently with the progress of the lesion, and in proportion to its extent and gravity, the constitutional disturbance becomes greater, the fever increases, the tongue becomes dry and brown, pulse becomes frequent and small, respiration is increased and sometimes embarrassed. In rare cases we see œdema of the lower extremities. Diarrhœa, wakefulness, and delirium have been noticed, and are sometimes followed by coma and death. The complications of this disease are various; an important one is the infiltration of urine, and destruction of large amounts of tissue; pyæmia may also result from it, as well as violent hemorrhage, particularly after the fall of the sloughs; and finally orchitis. The diagnosis of gangrene of the penis is generally easy, at any rate after it has existed a day or two. The prognosis should be guarded, as it is difficult to say to what extent or depth the lesion has attained. It may simply destroy the prepuce, and then is of very little moment, or even the glans, and the patient experience no inconvenience; but in cases in which one of the corpora cavernosa is involved, the results may be very serious, as the loss of substance is replaced by cicatricial tissue, the organ becomes bent at an inconvenient angle, and copulation and ejaculation are painful or impossible.

The patient becomes profoundly discouraged, and marasmus and death may finally end his sufferings.

M. Demarquay bases his indications for treatment upon the stage of the disease: In the period of invasion, to prevent it; in its period of progress, to arrest it; and in the stationary period, to destroy it radically.

The preventive treatment consists in accelerating the circulation by means of warm emollient applications, and in scarifying more or less deeply to relieve enlargement, care being taken to insert a pledget of lint saturated in aromatic wine into each incision. These means failing, more severe ones are necessary, and M. Demarquay places great reliance upon thorough cauterization with the actual canter, which transforms a gangrenous ulceration into a small wound. He thinks that arsenic and citric acid are powerless to cure the disease.

M. Demarquay does not advise amputation of the penis for gangrene, scarcely to cut away detached fragments, as, when the lesion results from external causes, the precise spot where it will stop cannot be foreseen, and, when it is due to constitutional causes, amputation of the part then affected does not insure that the systemic predisposition will not involve the other parts beyond; therefore it is a painful and useless operation. M. Demarquay thinks that amputation should at any rate not be

beyond the sphacelated part, but that the operation is sometimes admissible in cases where the gangrene attacks localized spots and leaves others intact, and as a consequence subsequent cicatricial contraction would distort the organ and render it useless. He finishes by referring to a preparation of camphor or creosote, recommended by M. Lavit, which has produced good results.—*Archives Générales de Médecine*, May, 1870.

Fungous Disease of the Testis, with deposit of Encephaloid Cancer in the Liver.—Mr. Rooke, of the Dreadnought Hospital, reports an interesting case of this kind. The patient, a weakly-looking Norwegian, was admitted July 16th, 1870, for an enlargement of the left testis of seven months' duration. The organ was of the size and shape of a goose-egg, but not nodulated. The scrotum covering it was normal, but stretched and not adherent. There was no history of traumatism nor any signs of syphilis. The body of the testis was the most involved, but the cord was slightly thickened. For six weeks, under observation, the tumor remained the same size, but then it increased in size and was painful, and the scrotum became red and inflamed. These symptoms rapidly increased in intensity, and soon there was perforation of the front of the scrotum at several points, sloughing of the tunica albuginea and the extrusion of a large gangrenous mass composed of the greater part of the diseased testis. The patient's health was, in the mean time, not much affected, and no secondary changes other than thickening of the cord were noticed. The large cavity formed by the removal of the testis was soon filled by luxuriant and rapidly-growing masses of granulation, which protruded and appeared like a well-marked malignant fungus. On Oct. 21st, when the inflammation consequent upon ulceration of the tunica albuginea had subsided, the testis and fungus was removed, and the cord was divided as close as possible to the external ring. The wound healed rapidly, and the patient progressed favorably until the third week of November, when he complained of debility and severe intermittent pain in the lumbar region and right side. On percussion there was marked dulness over the right hypochondrium and the whole epigastric region below the umbilicus. During the succeeding three weeks his symptoms were severe pain in the back and the abdomen, great debility, anæmia, constipation, and a slight posterior curve of the lower dorsal vertebræ. The temperature ranged normally. For the first five days in December the pain in the back was much relieved and the patient slept well, but on the evening of the sixth, after a sudden movement in bed, the patient complained of acute pain across the epigastrium, which was

followed by collapse and death in five minutes. Upon post-mortem examination, the liver and left kidney were the only viscera found diseased. The peritoneal cavity contained a pint and a half of bloody serum. The liver extended across the epigastrium to the left hypochondrium, compressing the spleen, while its anterior border reached to the level of the umbilicus. The surface of the organ was studded by numerous circular deposits of a soft consistence and a white color mottled with pink and dark red patches. The deposits varied in size and were found chiefly upon the upper surface of the liver, while some of them were umbilicated. Upon section, similar deposits, varying in size from a pin's head to a pigeon's egg were found scattered through the organ, each nodule at its periphery being in contact with healthy tissue. Microscopic examination showed that the neoplasm was encephaloid cancer. The liver tissue was pale and fatty and upon its peritoneal surface were patches of congestion. At its upper and posterior parts the liver was bound to the diaphragm by recent adhesions, and beneath to the stomach and intestines. The liver weighed fourteen pounds and a half, and in the left kidney was a small abscess. No disease could be found in the lumbar and iliac glands upon careful examination. The peritoneum covering the under surface of the organ was ruptured while removing the viscera. It is probable that the peritoneum covering one or more of the cancerous deposits had been ruptured during life, causing the hemorrhage into the cavity and speedy death.—*Lancet*, July 30, 1870.

Coincidence of Neuralgia of the Crural Nerve with Blennorrhagia. — Dr. Henry Coutagne, without expressing his conviction as to the truth of the etiological relation between urethral discharges and certain peculiar articular and nervous symptoms, reports two apposite cases of the latter complication :

CASE 1. A healthy young man, aged 18, who had not previously suffered from venereal disease or rheumatism, and whose family had not suffered from the latter disease, contracted a gonorrhœa, for which he was admitted on the 20th of November, 1868, to the Antiquaille Hospital. When the patient was admitted the disease was in its acute stage, and had then existed five days. Upon the first of December he complained of articular pain, which was seated in the knee, the elbow, and shoulders, but there was no swelling. At the end of December the pains had ceased, and the discharge had become mucous and scanty. He at this time had sexual intercourse, and again had a copious purulent discharge and articular pains. In addition he had a continuous pain, with short exacerbations, in

the integument of the anterior portion of the thigh, and in that of the scrotum in apposition to the thigh. Pressure made along the course of the nerve produced pain over the points where small branches perforated the vastus externus muscle and near the internal condyle. The pains in the course of the nerve continued, sometimes being accompanied with the articular pain, until the 20th of January, and then they ceased. The interesting points in the case are, the occurrence of articular rheumatism with each exacerbation of the gonorrhœa, and the pain in the course of the crural nerve, and in that branch of the genito-crural which is distributed to the integument of the inside of the scrotum.

CASE 2. A robust man, aged 20, never having had rheumatism, with no family history of that disease, was admitted February 25, 1869. He had contracted a gonorrhœa two years before, of which he had had several relapses, the last of which occurred twelve days prior to his admission into the hospital. Three months after the original appearance of his disease, he experienced a pain which radiated from the tuberosity of the ischium of the right side, in the thickness of the gluteal muscles. This pain, however, was not long continued, but was followed in three and a half months after by another pain over the distribution of the crural nerve. Upon admission patient presented a very severe gonorrhœa, and a pain in the right crural nerve, which was not very severe if patient was quiet, but which became very acute upon motion. The painful points were at the fold of the groin and where the perforating branches are given off, but did not exist below the knee. There were also developed transitory pains behind the great trochanter and at the internal condyle. The pain in the nerves was complicated with articular pain, which, however, did not last long. At the 7th of March, under appropriate treatment, after several cessations and relapses of the neuralgia, it ceased, and there only remained a mucous discharge from the urethra.

This case, then, presents a history of a chronic urethral discharge, which sometimes became acute, and was then complicated by neuralgia in branches of the lumbar and sacral plexuses. Dr. Contagne has observed other cases of a similar crural neuralgia, but they have been coincident with orchididymitis.—*Annales de Dermatologie et de Syphiligraphie, Deuxième Année.*

Clinical Observations upon Prurigo.—Dr. Tilbary Fox thinks that much more has been written upon this subject than clinical observation warrants. He insists upon a clear distinction between prurigo lousiness and pruriginous eruption,

which are too loosely regarded as prurigo. He thinks that the fact that papules arise from a rich variety of causes, as congestion of follicles, lymph deposit in papillæ, and papules, secondary to wheals, and that all present, when scratched, an apex covered with a crust of dried blood, and might each be termed a pruriginous papule, should lead observers to carefully differentiate each lesion. He thinks that while in prurigo the papule is the primary lesion, a deposit of lymph in the skin, in phtheiriasis the primary lesion is a minute hemorrhage and not a papule. He quotes the observations of Professor Schjödte, who proves that the wound of the pediculus is produced by sucking rather than biting. The mouth of the pediculus is furnished with a labium capable of retraction to the upper part of the head; this lip is first inserted into a sweat duct, and then protruded; a row of hooks then hold to the parts around, and two pairs of setæ are next protruded, and applied together so as to form a tube. When the pediculus sucks, a red speck is seen at the top of the head which exhibits dilation and contraction. This redness is soon traced into the œsophagus and intestines, which undergo lively peristaltic action. The effect of the attack of the pediculus is to cause an escape of a little blood into the follicle, which appears as a minute, and at first bright red, speck double the size of a pin's point, not raised, not itchy, not removable by pressure. Swelling may take place, but it soon subsides. This lesion evidently differs from a scratched follicle, and can readily be seen upon lousy persons. But it must be remembered, that there are accidental appearances in phtheiriæ, which are due to scratching, such as congested follicles and papules, urticaria and ecthymatous pustules; these are also seen in scabies. The production, then, of minute traumatic hemorrhagic specks, not the result of alteration in pre-existing papules and excoriations, and not due to scratching, is the pathognomonic sign of phtheiriasis, an affection totally different, as Hebra has shown, from true prurigo.—*Lancet*, July 30, 1870.

Pityriasis Rubra.—Drs. J. H. Benson and W. G. Smith report a case of this disease, which is interesting from its rarity and its amenability to treatment. The patient, aged forty, a laborer, noticed without any premonitory symptoms, little red spots on the trunk and abdomen, which became confluent, and produced a continuous red surface from head to foot, and upon pressure a yellowish color was seen. This was followed in a few days by a general epidermal exfoliation in laminæ of the size of a nickel cent. These laminæ were very abundant, thin and lustrous like silver paper, and easily rubbed off. The

patient experienced no itching except a very inconsiderable amount at night, but complained that his skin was hot and parched, and he was indisposed to bend the joints lest the skin should crack, but there was no infiltration. The conjunctivæ were slightly injected, and the tongue was abnormally red, especially at the margins and tip, and was covered by a white fur, which, being deficient in patches, exposed the reddened mucous membrane. The epidermic scales were cast off abundantly, and very quickly reproduced, the hard cuticle of the palms of the hands was shed, and that of the soles of the feet desquamated in the form of flakes resembling sandal. The nails were unaffected, nor did he have rhagades in any part of the body. It was estimated that the scales daily cast off would fill a six-ounce measure glass. He had been perfectly healthy until the appearance of this eruption, and when first seen was slightly emaciated, and so weak that he sought his bed. His pulse was over one hundred, and compressible, he was very susceptible to cold, and shivered continually, and his temperature averaged a little above 99° Fah. His bowels were regular; his urine, which was scanty and high colored, contained an excess of phosphates. He was treated locally by warm alkaline baths and emollient ointment, both of which were continued throughout the treatment. Quinine, iron, mineral acids, strychnia, and belladonna were powerless, and his debility steadily increased. Then he was treated alternately by Fowler's solution, and De Volangin's solution, upon which his health gradually improved, the scales became smaller and less abundant, and the redness grew less. At the thirteenth week from the appearance of the disease, and the seventh from the commencement of the treatment, all trace of desquamation had disappeared except about the head, and the skin was nearly of its natural color and pliancy, except that there were brownish red patches of skin over the body, of the size of a cent, from which the color did not disappear by pressure. The fact of the very slight increase of the temperature and slight acceleration of the pulse is very interesting when one considers the extent of the lesions.—*Dublin Quarterly Journal of Medical Science*, May, 1870.

Alopecia Areata caused by the use of Arsenic.—Dr. Oscar Wyss, of Zürich, being convinced of the non-parasitic origin of this disease, and adopting the views of Pineus and Rindfleisch, reports the following case, as showing that the disease is due to the impaired nutrition of the hair. A boy, six years of age, was brought to Dr. Wyss, with a history of epileptiform seizures, which had existed at irregular but frequent intervals

since he was ten weeks old. He was placed upon Fowler's solution on the sixth of April, and took it, reaching doses as high as five drops, until the end of July, and then there was no improvement in his nervous symptoms. At this time it was noticed that his hair fell, and that over the occipital protuberance there was a round bald spot. There were upon this spot some scattered black hairs to be noticed, and the integument presented the same appearance as in alopecia areata. No fungi could be detected upon the hairs. The arsenic was immediately stopped, and at the end of two months the hair had grown out upon the bald patch, did not fall out elsewhere, and otherwise appeared healthy. The fact has previously been noticed by Faek and Hlessert that after a long continued use of arsenic the hair sometimes falls, but there is no mention of its occurrence in circumscribed spots. Dr. Wyss thinks that the fall of the hair was due to enfeebled nutrition of the integument of the head and hair bulbs produced by arsenic rather than by a disturbance of innervation.—*Archiv der Heilkunde*, 1870.

On Feigned Cutaneous Affections.—Dr. C. Hilton Fagge gives an account of several of these cases which have come under his notice. The first is an artificial gangrene of the skin produced by a girl upon herself with nitric acid. She had on her face and chest several dry, apparently gangrenous, patches in different stages of development. The more recent were of a smooth yellowish color, and the older of a dirty brown hue. Some of the patches were tender, in others there was no sensation. Elsewhere upon the body were blebs, and erythematous and excoriated spots. The patient said that eight days before admission she felt a burning sensation on the neck, and upon looking at the glass she discovered a blister; this was soon followed by others. It was noticed that the tips of the index, middle, and ring fingers were stained of a bright yellow color, such as is produced by nitric acid. On the ring-finger the stain ran along the sulcus between the side of the nail and the skin. After her admission into the hospital no fresh patches appeared, and the site of the eschars was marked, upon healing, by superficial cicatrices.

The second case was that of a female aged eighteen, who had on various parts of the thorax and arms dry gangrenous patches, surrounded by an inflammatory redness. These patches presented different appearances, according to their age; the older were dry, yellow, and shining, and depressed below the surface, the new ones were red, slightly raised, and papulated. Sensation was impaired over the patches, but the girl was not hysterical. She had lived as a servant, and fared badly. She

stated she had had the same disease a year before, and slight cicatrices on the legs attested the fact. The case, though at first regarded by Dr. Fagge as one of circumscribed gangrene of the skin, was finally diagnosticated as one produced by escharotics.

A third case is mentioned, occurring in the practice of Mr. Birkett; it was that of an hysterical girl, who complained of a lump on the breast, the result of a blow, which, however, could not be discovered; but the organ was seen to be covered with red patches, evidently the result of irritants. Chancing to visit the wards at an unusual hour, Mr. Birkett discovered a piece of lint covered with powdered cantharis in the girl's possession. It was taken away, and the girl had no more red spots.

Mr. Thomas Flower also reports a case of feigned skin disease. The patient, a healthy girl, had on each cheek a bright scarlet blush, which she said was painful and tender. She said she had been laid up five weeks by a similar rash affecting various parts of the body. The erythema upon the cheeks remained three days, faded and desquamated, and was followed by similar rashes elsewhere; one spot over the hip, however, resembled urticaria. A mustard plaster was applied by the house physician, and retained three hours, and the redness produced by it resembled the spots elsewhere. She denied using it, but had no more rashes while in the hospital. After her departure dried mustard was found in the fire-place.—*British Med. Journal*, Feb. 12 and March 26, 1870.

Microscopic Appearances of Molluscum Fibrosum.—Dr. C. Hilton Fagge read a paper upon this subject before the Royal Medical and Chirurgical Society of London, which was based upon the dissection of portions of the integument of a woman, aged 40, affected with molluscum fibrosum, who died at Guy's Hospital of another disease. Dr. Fagge examined the smaller tumors, while a separate examination of the larger ones was made by his colleague, Mr. H. S. Howse. The specimens were hardened in chromic acid, and fine sections were examined with high objectives. The conclusions arrived at were as follows:

1. Each tumor is originally developed around a hair-follicle, inclosing at the same time the sebaceous glands belonging to the follicle.

2. The smallest tumors consist of two distinct elements: a central glandular body, itself surrounding a hair, and a peripheral mass of very fine connective tissue, containing numerous minute oval nuclei.

3. The glandular body is a sebaceous gland enlarged by the

separation of its sacculi from one another, and perhaps also by actual multiplication and increase in size of the sacculi themselves.

4. The peripheral mass of nucleated connective tissue is developed from the two external layers of the dermal coat of the hair-follicle and sebaceous glands.

According to Dr. Fagge's observation, the name *molluscum fibrosum* is more appropriate than that of *fibroma molluseum*, of Virehow and other German writers.—*British Med. Journal*, July 30, 1870.

Herpes Zoster of the Face and Tongue.—The following case is reported by Dr. C. J. Ermerins, of Amsterdam (*Med. Tijdschr.*, 1 afd., p. 257, Mei, 1869; quoted in *Schmidt's Jahrbücher*, June, 1870, p. 277):—A woman, aged thirty-three years, suffered for two days from shooting pains in the right half of the face, at the end of which time there appeared on the right cheek red spots, which were soon succeeded by vesicles. At the same time the tongue swelled, deglutition became painful, and there was salivation. In two days the disease reached its acme: from the ascending ramus of the inferior maxilla to the ala nasi stretched a stripe of three fingers' breadth, upon which there were closely aggregated vesicles on a dusky-red ground. They had become so confluent that the individual groups were no longer distinguishable; they contained a sero-purulent fluid, and were in part ruptured, and in part encrusted. The right half of the tongue was swollen, red, and covered with discrete herpetic vesicles of the ordinary size. Upon the right half of the soft palate were three groups of five or six vesicles each. The mucous membrane of the right cheek also was studded with vesicles, partly discrete and partly arranged in groups. The right sublingual and submaxillary glands were swollen. The lips were free from eruption. Two days later, incrustation was complete on the outside of the face, and after the falling off of the crusts, one week subsequently, only red spots were to be seen. Within the month no crusts were formed, but only erosions, which disappeared in four days. A moderate neuralgia persisted for a week after the completion of the process.

Relations of the Epidermis to the Derma.—Dr. Auspitz endeavors to show, in an article "On the Normal and Pathological Relations of the Epidermis to the Papillary Layer of the Skin," that though the papillary layer of the skin is ordinarily considered to grow into the epidermic layer, which receives the impressions of the papillæ as soft wax takes the impression of

the finger, another view may be entertained, viz., that the epidermis plays an active part in relation to the stroma of the corium; both anatomical facts and a consideration of the development of the skin in the embryo favoring the view that in the development of the papillary layers, as in that of the glands and hair-follicles, the epidermis may, and actually does, play an active and important part; and in fact, that we may regard the papillary structure as due to the penetration of the corium by columns of cells of the epidermis, the apparent papillæ of the corium being the parts not eneroached upon. Taking this for granted, he proceeds to discuss the nature of the various pathological conditions more or less immediately connected with inflammation, and arrives at the following conclusions: 1. In hyperæmic and inflammatory processes occurring in the skin, the papillæ are found to be only succulent and slightly swollen; but no modifications of form occur, unless consecutive to secondary changes in the Malpighian stratum. 2. In simple and lymphatic hypertrophy of the connective tissue matrix, as well as in cell-infiltrations of the corium, the same law holds. 3. In the keratoses, or horn-producing affections—ichthyosis—there is either no change in the form or size of the papillæ, or it is due only to the pressure of the hypertrophied horny layer. The prismatic and columnar forms of the latter are by no means dependent on the papillæ of the cutis. 4. The papillomata (warts, condylomata, epithelioma) originate essentially in an active neoplastic process taking place in the rete, which penetrates to a greater or less extent into the likewise hypertrophied connective tissue matrix of the corium. The papillæ of the cutis here, too, perform only a passive rôle, their elongation and dendritic form being occasioned by the hypertrophy of the epidermis; whilst the elevation of the surface of the skin is due to hypertrophy of both. 5. An outgrowth of the connective tissue of the skin sometimes occurs, but is never dependent on the pre-existent papillæ. 6. There is no essential anatomical difference between the several forms of papillomata, warts, pointed condylomata, and cauliform excrescences. The syphilitic condyloma differs from these only through the specific cell-infiltration of the corium. 7. Epithelioma represents exquisitely the types of the hypertrophic growth inwards of the epidermis into the connective-tissue matrix.—*Lancet*, July 23, 1870, and *Archiv für Dermatologie und Syphilis*.

Tinea Circinata of Hand.—Dr. Tilbury Fox reports the case of a boy, twelve years of age, having a patch of tinea circinata, of a diameter of three inches, involving the wrist and

part of the palm. The case was remarkable from the fact that, while upon the wrist the appearances were those of ordinary ringworm, upon the palm there was a resemblance of slight psoriasis, presenting a peeling of the cuticle rather than any thing else. Dr. Fox remarks that he has already described a species of erythema occurring upon the hands and fingers, in which the skin becomes red in circular spots from which the epidermis peels centrifugally, leaving a red dry surface, marked by circular ridges of normal papillæ. He now regards these cases as parasitic, as examples of *tinea circinata* modified in appearance by the peculiar horny structure of the palmar integument. He thinks that the parasite disturbs the epithelial growth, and induces peeling, but does not produce herpetic eruption, and serous effusion. The case reported proved that the disease presented a different appearance on the palm to that which was noticed on the wrist. It differed from psoriasis, in the absence of thickening and heaping up of epithelial scales, or papillary hyperæmia. He thinks, then, that the cases in which the epidermis simply peels off in circular patches about the palm are very probably of parasitic origin.—*British Medical Journal*, July 30, 1870.

Hydroa.—This disease, an old one, perhaps, re-named, has lately been very fully described in the *British Medical Journal*. It would seem from its clinical history that some cases present appearances peculiar to it alone, while others show resemblances to diseases otherwise named. The diseases which it in a measure resembles are, urticaria and the various forms of erythema, and perhaps mistakes might be made between it and the vesicular syphilide, varicella, and variola. As a rule, it has a definite duration, and disappears spontaneously in a few days, and may be accompanied by slight fever. The first phenomenon noticed is a faintly-marked, rosy spot, which is soon replaced by a single vesicle, which may remain intact or may become umbilicated, or may dry up and become an umbilicated crust of a yellowish-white color. Around this vesicle, inflammatory changes very soon take place; a zone of a color varying from red to violet, with a well-defined, slightly elevated periphery, forms, and then around this perhaps a ring of small vesicles, which may coalesce and form a circumferential bulla. These spots vary in size from a line to four or five, or even more. There is no hyperæmia between the patches, as the inflammatory action is sharply confined to them. This condition differs from that of herpes phlyctenodes, in which the inflammatory areola is not thus sharply defined. There is usually no pain or itching, merely a little heat or a feeling of tension.

The same appearances, somewhat modified, have been observed upon the buccal mucous membrane. The eruption disappears by the fall of the crust, which is formed from the vesicle, and is generally seen in the centre of each patch, and then there remains a more or less well-marked hyperæmia with slight infiltration. The sites of election are the back of the hands, the forearms, face, neck, and also the trunk and lower limbs. It is generally symmetrically developed.—*British Medical Journal*, May 14, 1870.

Acute Pemphigus following Chronic Gastralgia.—Dr. A. Chatagnon reports the case of a woman seventy-one years of age, who had had severe attacks of gastralgia, which had lately become more frequent and prolonged. Dr. Chatagnon had attended her during five months for these gastric paroxysms, when she complained of a general itching over the body, and erysipelatous patches were noticed, which quickly formed bullæ, which in time burst and collapsed, and the uplifted epidermis desquamated. The patient had no attacks of gastralgia for some time previous to the appearance of the rash nor since. Dr. Chatagnon thinks the case is remarkable from the fact of the eruption being so universal, from its desquamation in very large, thick scales, particularly upon the palms, soles, and heels, and its occurrence after severe gastralgic paroxysms.—*Gazette des Hôpitaux*, June 14, 1870.

A Third Attack of Herpes Zoster.—Dr. Tilbury Fox reports the case of a man, aged 33, who had an interrupted band of well-marked herpes zoster crossing from front to back, over the point of the right shoulder. The case was interesting from the fact that the man, who was very reliable and intelligent, said that he had had two previous attacks, one in 1869 and the other in 1868, each year in the month of June. Each attack is accompanied by herpetic patches upon the penis, and the present one was ushered in by a crop of vesicles upon the gluteal region. The case is interesting in the fact that, contrary to the general view, second and third attacks of zoster occur.—*British Med. Journal*, Aug. 6, 1870.

Contagious Impetigo.—Dr. Fox also reports that several cases of this disease have lately come under his observation, and that he has noticed that it sometimes presents a *quasi* epidemic character. He is disposed to regard it as one of the minor acute febrile diseases, resembling varicella. (A full clinical history of this interesting disease, as detailed by Dr. Fox, was given in our April number.)—*British Med. Journal*, Aug. 6, 1870.

The Delhi Boil.—A discovery has recently been made, which promises to throw a great deal of light upon the pathology and treatment of a very common and intractable form of ulcer, prevalent at certain stations in India. There is every reason to believe that the true explanation of the occurrence of the Delhi sore has not hitherto been given, and that neither the chemical character of the water, such as the presence of nitrates or nitrites in it, nor the condition of the station, has any thing to do with its production. From several observations, Staff Assistant-Surgeon Fleming was induced to believe that the affection was of local, not constitutional, origin; that it was caused by an animal parasite or its ova, or both; and that thorough destruction of the tumor, on its first appearance, by a strong caustic solution was the remedy. We are indebted for our information to a paper by Dr. Fleming in the *Indian Medical Gazette* of Nov. 1st. The Delhi boil is a misnomer; it is described as a morbid growth affecting the skin and subcutaneous tissue, and without signs of inflammation, until the ulcerative stage. During the growth of the tumor, and up to the period when ulceration begins, it appears relatively transparent and shiny, and one or more yellowish spots may be detected in it by the aid of a lens. If one of these spots be cut down upon with dissecting needles, a small, round, yellowish body, with a glistening capsule, just capable of being discerned by the naked eye, will make its appearance, and can readily be removed. Drawings of two of these bodies are shown, with the aid of the camera, magnified. They are seemingly composed of an apparently fibrous envelope, arranged in concentric laminae, inclosing fluid contents and probably something else. Dr. Fleming hazards the conjecture that they are parasitic ova of some kind. Curiously enough we understand that Surgeon-Major Smith recently forwarded an official document to the authorities, in which he has detailed his researches, which are said to be of a more extended character. He has arrived at conclusions in this respect identical with those above-named, viz.: that the disease is due to the presence and development of ova obtained from the water used for washing, in the affected parts. Dr. Smith's paper will probably be published in the next Army Medical Blue-Book. In the mean time the medical authorities in India have been requested to prosecute the inquiries still further. The drawings illustrating Dr. Fleming's paper do not enable us to identify—at any rate, with certainty—the exact nature of the parasite.—*Lancet*, Jan. 1, 1870.

Urticaria complicating Small-Pox.—A case occurred at the Hôpital Beaujon, under the care of M. Gubler, of a non-

vaccinated female, who upon the third day of a variolous eruption of a severe character, became covered with urticaria, attended with intense pruritus. It lasted three days, during which the variolous eruption remained stationary. Variola then resumed its course, and the patient eventually rallied, notwithstanding such bad symptoms as epistaxis, rachialgia, vesical paralysis, and a vinous hue of the pustules.—*Lancet*, January 1, 1870.

Termination of Nerves in the Epithelial Layer of the Skin.—Dr. Podcopaw states, in the last number of Max Schütze's *Archives of Physiology*, that he has been able to trace the nerves into the epithelial layer of the skin of the rabbit and other animals, by means of solutions of chloride of gold. Branched lines come into view lying between the cells of the rete, continuous with easily demonstrable nets lying beneath the rete. From the former, very delicate darkly-tinted lines may be traced, which run up between the epithelial cells, and near the surface again form fine plexuses. The subepithelial plexus of nerves consists of non-medullated fibres, on the sides of which a few nuclei are attached. It thus appears that a distinct nervous plexus exists between the rete mucosum and the proper laminate epithelium.—*Lancet*, December, 1869.

Gangrenous Affection of the Skin.—Mr. Stockwell gives an account of this lesion in a girl twenty-two years of age. The gangrene commences in small red spots, which are always preceded by general feverishness and pain about the right hypochondriac region. The red spots became black in about three days, extend circularly for about fourteen days, then become dry and separate. The whole process takes about six weeks, leaves a circular granulating surface of the size of the palm of the hand, which heals in from two to six weeks. Hitherto the disease has been limited to the legs and thighs, she having fifty-five spots on the left leg, and twenty on the right. When she takes cold she always has an ulcerated throat. Five years ago she had what she called "glass poek," which is a crop of boils. After a combined mercurial and iodide of potassium treatment she was exempt for a year. Free incision around the margin of the spots, and passing the knife under the connective tissue is the only means of arresting the progress of the gangrene.—*British Medical Journal*, February 12, 1870.

Ichthyosis of the Tongue.—At a recent meeting of the Clinical Society of London, the president, Mr. Paget, described

the ease of a lady who had suffered from ichthyosis of the tongue for a year when she consulted him. The patches occupied the papillæ, and showed no indications of cancer. Four months afterwards, however, they became thickened and indurated, and soon presented appearances of well-marked ulcerated epithelial cancer. There was hereditary cancerous tendency in the family.—*Lancet*, March 5, 1870.

Parasitic Disease produced by the Larva of *Æstrus Bovis*.—Dr. R. Walker reports the ease of a girl who complained of a pain behind the shoulder, having felt it for a fortnight previously in the lower part of the back, then it ascended to the present spot. On examination, a red tortuous line resembling an inflamed lymphatic was seen extending from the left loin to the middle of the scapula. Towards its lower extremity it was indistinct and purplish; at its upper extremity it was very red and painful, and here, amid some œdema, a hard lump was felt. Dr. Walker, suspecting the larva of *æstrus bovis*, cut through the skin and ejected the intruder. This is mentioned as a good example of the disease as seen in Shetland. In the human subject the larva moves rapidly under the skin, whereas in the ox it remains stationary; this is probably owing to the different characters of the connective tissue.—*British Med. Journal*, Feb. 12, 1870.

Scarlatina and Measles occurring Conjointly.—Dr. J. Alexander Ross collates the views of several medical writers—among them Drs. Copland and Hebra—as to the existence of such a disease as a hybrid of scarlet fever and measles, and relates three cases that fell under his own observation, in which some of the symptoms of the two diseases were conjoined, viz.: On the one hand, ocular, nasal, and bronchial catarrh and the eruption indicative of measles; and, on the other hand, sore throat, strawberry tongue, and albuminuria, with dropsy in some cases.—*Med. Times and Gazette*.

Lice as a Cause of Prurigo Senilis.—Attention has of late been drawn to the part played by lice in the causation of prurigo senilis. Out of fifty-five cases of the disease, in which Mr. Hutchinson searched for lice, they were found in fifty-two. The reporter, Mr. Nettleship, adds that "It seems possible that a single attack of pedicularia may establish, in persons of irritable skins, a more or less permanent pruriginous condition; so that very slight causes (*e. g.*, increase of external temperature or moisture) may afterwards induce repeated severe attacks of prurigo."—*British Med. Journal*.

Therapeutical Notes.

On the Treatment of Syphilis without Mercury.—Dr. M. A. Desprès read a statistical paper upon this subject before the Imperial Society of Surgery of Paris, detailing the results of his observations at the Lourcine Hospital. During a year he had treated 311 syphilitic patients. Of these 81 had previously taken mercury—10 during more than four months; 37 more than two months; 20 for one month; and 20 less than one month. Forty-one have returned to the hospital for treatment, having previously undergone a tonic course; of this number 11 were treated more than two months, 14 went away relieved, and 10 are not cured.

Including the above number and the syphilitics received during four previous years, M. Desprès has in all treated 1,199 patients, without mercury, by tonics, rest, baths, and local applications. Of these 273 had previously taken mercury and 112 who had not taken mercury have re-entered the hospital for relapses. Among this number of relapses no grave symptoms had shown themselves, being mostly mucous patches. Among this number 35 had had three relapses, of which number, 24 had been treated by mercury at the first relapse, and nine had been treated without mercury. The figures then stand thus: Eight per cent. of those who had not taken mercury had relapsed three times, to twenty-two per cent. of those who had taken mercury and had relapsed three times. M. Desprès says, that, in patients who have not taken mercury, the relapses occurred early in from twelve to sixteen months; whereas, in patients who had taken mercury, they occurred in from eighteen months to two years; consequently he thinks that mercury merely retards the eruptions rather than renders them less severe. Another fact considered significant is the following: A woman was treated with mercury for two months at the first appearance of secondary symptoms; in a year she had a relapse of mucous patches and a papular syphilide; she was then treated without mercury, and had an insignificant relapse, for which she took mercury for six weeks at the St. Louis Hospital, which did not prevent a fourth and very grave relapse with great anæmia, for which she was treated by tonics. Among the 926 patients who had not taken mercury, including

the statistics of four years, there had been but three cases in which tertiary lesions followed, and they were not grave; whereas in the 273 cases treated by mercury, he has had such grave lesions as exostoses, palsies, amauroses from retino-choroiditis, gummy tumors of the palate, gummy tumors of the skin, onychia, ulcerating and non-ulcerating tubercular syphilides. Most of these cases were in their fifth year of syphilis. M. Desprès thinks that if, after treatment, syphilitic symptoms do not show themselves in three years the patient may be considered cured, but he has seen grave cases in which cures were obtained in eighteen and twenty-one months. As regards the treatment of iritis and choroiditis M. Desprès simply advises rest of the organ, counter-irritation to the temples, purgation, and mydriatics and closure of the eye, and in women he applies sinapisms to the thighs during the menstrual epoch. He then gives his observations upon the treatment of syphilis during the parturient state. There were twenty-six syphilitic women delivered of children in the hospital; of these sixteen had not taken mercury, nine had taken mercury for six months, three for three months, one for one month or less. Of the sixteen who had not taken mercury, five went to full term or to the eight and half months, bearing healthy and living children; eight had aborted, or were delivered before term of dead children; three had had children at or a little before term, which died either within one or seventeen days. Out of the nine cases treated for six months with mercury, three had had living children, of which one lived three months, and one still lives and has mucous patches, while the third lives and thrives; the five aborted, with putrid children, and the remaining one of the nine had a child, a little before term, which died the same day. The mother of the child mentioned above as thriving took a very small quantity of mercury as she had syphilis mildly; and the mother of the living child having mucous patches had taken twenty pills of the proto-iodide of mercury, while the mother of the child which lived three months had taken mercury for five months. In comparing the results between patients who had and those who had not taken mercury M. Desprès fixes the proportion of abortions at fifty-five per cent. for the former and fifty per cent. for the latter, while he reckons against his own figures two doubtful cases,—one of abortion from a fall, the other a patient who aborted as soon as she entered the hospital.

M. Desprès further gives his results in cases in which syphilitic contagion is coincident with fecundation: out of eight of such patients, six have aborted, while two have brought

forth healthy children. The two who had healthy children had not taken mercury and were primiparas, while, of the six which aborted, one only had taken mercury for a month.

Out of eleven women who had become syphilitic during pregnancy, four aborted—all having taken mercury; two had children, which lived twenty-four hours, one of which had taken mercury; two others had children which lived six weeks, one having taken mercury, and three had healthy living children, while only one of them had taken a very small quantity of mercury.

Among five patients who were syphilitic six or eight months before pregnancy, three aborted, all having taken mercury before or after pregnancy; the remaining two gave birth to living children, one of which had mucous patches, and its mother had taken mercury for five months. M. Desprès thinks that, from these statistics, proper conclusions can be shown as to the inefficacy of mercury. He advances the hypothesis that syphilis is an infection of the blood which tends to spontaneous elimination, and that all syphilitic manifestations are mere capillary infarctions, and that in proportion as these manifestations, whether they are syphilides of skin or mucous membranes, are copious, so is the eliminative process active, and that mercury is baneful in retarding or preventing this eliminative evolution; whereas rest, tonics, baths, and mild cauterizations expedite the process. As regards the destruction of such syphilitic lesions as ulcers and papules by caustics he thinks it hastens the curative process by destroying just so much effete material. If his tonic course is pursued he thinks that the visceral lesions of syphilis do not occur, whereas, if the natural evolution of the disease is disturbed by mercurial treatment they are very likely to be produced. He admits, however, that complex visceral lesions are found in scrofulous, phthisical, and rheumatic patients who have not taken mercury.—*Gazette des Hôpitaux*, July 19, 1870.

The Treatment of Syphilis without Specifics.—Dr. H. Œwre, of Christiania, has, since 1863, treated eighty cases by what he terms symptomatic treatment. He does not, however, claim any unusual results from it, as he says that relapses may occur, and that when thus treated, syphilitic pregnant women may bear diseased children. He states, however, that the number and severity of the relapses are not increased, and that but few cases of tertiary syphilis are observed after its use.

He treats primary sores like simple ones, with cleanliness and astringent solutions, and, if phagedena develops, uses caustics

energetically. The inguinal adenitis of syphilis receives no treatment, unless the usual surgical procedures in case of supuration. He treats by the expectant plan the early symptoms of the contagion, he has used quinine and iron, but does not think they yield positive results. For the cephalalgia he has with benefit used quinine in doses of from five to ten grains, three times a day, and, when it occurred severely at night, has used morphine hypodermically. He rarely institutes any treatment for the cutaneous rashes, at most a warm bath for the papular and pustular eruptions. Alopecia is treated locally by stimulating lotions and friction. And the laryngitis is generally left alone, unless ulceration has taken place.

Syphilitic lesions of the eye should be treated antiphlogistically by leeches and cold and continuous use of atropia (lesions of the retina excepted). He thinks that mucous patches should not be left alone, but should be cleansed frequently and touched with caustics. He reprobates excision and the dusting with calomel. For pharyngitis, alkaline gargles and caustics answer an admirable purpose. All other secondary manifestations he treats locally, without regard to their syphilitic nature, and bases his theory upon the following considerations:—

I. The want of success of all other methods.

II. The disagreeable nature of other methods (restriction in diet and sweats), and their danger (mercurials and syphilization).

III. The unsettled forms of the so-called antisymphilitic methods.

Dr. Œwre remarks that his treatment requires, on the part of the physician, foresight, in not yielding to the inclination to internal treatment, and patience in the often-repeated visits necessary for the patient. In cases where it is necessary to give medicine, he advises the prescription of placebos. As regards the time required for this symptomatic treatment, an accurate knowledge of the clinical history of the disease, with its numerous relapses, will prove that it cannot be accurately stated. Œwre thinks that his treatment tends to shorten rather than lengthen the secondary period, which Dr. Boeck fixes at 120 days, and Zeissl at from three to five months. An advantage claimed for the symptomatic treatment is, that it incurs no restriction from business, and affords opportunity for plenty of fresh air. Dr. Œwre, early in the disease, allows stimulants, such as wine and beer, besides a very liberal and nutritious diet, to obviate the tendency to blood-deterioration, which he thinks is augmented by all other methods. He thinks that his treatment is indicated by the natural tendency of syphilis to

die out in the economy, and that this tendency is allowed full scope by a judicious let-alone treatment, and retarded by one in which mercury is employed, as that and iodide of potassium, and sweats, etc., only impoverish the blood, and lower the vital force. In the treatment of tertiary lesions, he thinks iodide of potassium is equally as powerless as mercury is in secondary lesions, and that a specific action has been attributed to it for effects which are really the natural resolution of the various lesions. He significantly remarks, that some observers claim good results from it in the secondary period.—*Archiv für Dermatologie und Syphilis*, No. 2, 1870.

Diday on the Treatment of Syphilis by the Subcutaneous injection of the Bichloride of Mercury.—At the meeting of the Lyons Medical Society, M. Diday detailed the results of a trial of this method in twelve cases. He used the same syringe as is employed by Liégois, and the solution recommended by the latter gentleman. Two, and even three, injections of from seven to eight milligrammes were used each day, and the seat of injection was the back and sides of chest, and anterior and external portions of the thighs. M. Diday thinks favorably of the treatment as a means of bringing the mercurial into action in a more direct manner than by other methods. He had selected twelve very severe cases, which had resisted other measures. M. Diday says that "his results, incoherent and even contradictory as they seem at first sight, cause him great embarrassment in pronouncing an opinion. In fact, there is no occasion to pronounce a positive opinion on so recent a remedy. At first, one is struck and seduced by the promptitude of some of the cures which it effects, only to fall again into a state of doubt in observing it to be powerless in other analogous conditions, or even in some less serious in appearance. We must not allow this doubt to pass into discouragement without further information. Deeper researches, instituted while varying the formulæ, and only injecting every two or three days, in order to prolong the time necessary for the cure, and perhaps by adding the employment of other agents, etc., will, it is to be hoped, lead to more constant results, and less vague conclusions concerning the degree of power of this mode of treatment, and its special adaptation to certain forms of syphilis. Above all things, we ought, in this channel of absorption as in others, not to limit ourselves to a mercurial preparation. As it is so well known since the able demonstrations of our legislator in therapeutics, Ricord, we should, according to the periods or age of syphilis indicated by this or that lesion, administer mercury to

one patient, iodine to another, and a combination to a third. Beyond this rule there is no safety. M. Diday thinks that it is especially useful in the scaling syphilides, and that it is useless and even mischievous in the ulcerative lesions. A great advantage is certainly obtained by the immunity of the digestive organs. In none of M. Diday's cases was ptyalum, however slight, produced.—*Medical Times and Gazette*, Sept. 3, 1870.

Treatment of Syphilis by Mercurial Suppositories.—Dr. Lebert, proceeding on the well-known fact that next to subcutaneous injection the best method of absorption is by the mucous membrane of the rectum, has experimented with various substances, and among them mercury, in the form of suppositories. He employs cocoa butter as the menstruum, or, if a firmer consistence is desired, uses wax, in which the mercurial ointment is rubbed up. Should the suppositories produce burning pain, morphia should be added. They should be introduced into the rectum at night. In three or four days the cure is effected, with the employment of from twenty-five to thirty suppositories. The mouth was not in any instance affected.—*Wiener Medizin, Wochens*, No. 27, 1870, and *Practitioner*, Aug., 1870.

Treatment of Syphilis by Creosote and Carbolic Acid.—Mr. John Morgan, surgeon to the Mercer's Hospital, has treated a large number of cases of syphilis by large doses of creosote, thinking it useful in cases where mercury is contra-indicated, and in strumous subjects. This treatment, though not generally so, is curative in many cases. The cases selected were those of the syphilitic constitution, presenting the early manifestations. The treatment required confinement to bed, but allowed a nourishing diet. A warm bath, containing two ounces of carbolic acid, in which the patient remained half an hour, was given every other night. The acid was in this manner supposed to act upon the skin. The patients took the creosote mixed in mucilage, with a carminative in doses of about seven drops, three times a day. The following was the formula:—

R—Creosote,	3j.
Mucilaginis,	3j.
Tr. Opii,	3j.
M—Aq. Menth. pip.,	3 vij.

One tablespoonful four times a day.

Improvement noticed in ten days. Mercurials were conjoined in urgent cases, such as iritis.—*Med. Press and Circular*, January, 1870.

On the Use of Carbolic Acid internally in Syphilis.—Dr. Moritz Kohn has used carbolic acid in Hebra's wards upon twenty-four patients, ten male and fourteen female. The cases were mostly those of the early exanthems, but not of the ulcerative form. The acid was given in the pilular form, made up with licorice-extract, each pill containing 0.06 gramme of the acid. The dose at first was six to nine pills, which later on was increased to twenty daily, while in some even sixty were given. When taken in solution, the acid was intolerable to the patients. Under this treatment the rashes disappeared in from four to seven weeks. The conclusion is, that the acid was not to be recommended, that it acted less rapidly than mercury, and that it was powerless in the cure of osseous lesions, arthralgias, and cephalalgias.—*Archiv für Dermatologie und Syphilis*, 1869.

Carbolic Acid in Severe Syphilitic Ulceration of the Throat.—Dr. C. Swaby Smith, of Liverpool, reports the case of a syphilitic woman who came to him with very severe ulceration of the throat. The tonsils and uvula were destroyed, the whole of the pharynx was in a sloughy condition, and a discharge issued from the nares. The soreness was so severe that she could hardly swallow even liquid food, and the stomach became very irritable from fasting and the irritation of the pus from the throat. She had become emaciated very much, and was weak in the extreme. Dr. Smith applied to the diseased surface Calvert's carbolic acid (made fluid by the addition of one-twentieth of its bulk of water). The effect was to bring away the offensive and tenacious secretion. She took internally iodide of potassium, cinchonine, and opium, and was allowed liquid albuminous food. The next application was composed of one part of carbolic acid to sixty of water, and was continued twice a day for two weeks; then an application of one part of the acid to thirty of glycerine was used. This, however, owing to the rapid progress of the case, was only used at first every second day, then less frequently. In about two months the general condition was very much improved, and deglutition was unimpaired. There is, however, a slight discharge still from the nares, probably from dead bone, and for this she injects the solution of carbolic acid, one part to sixty of water. Dr. Smith thinks that the interesting point is the rapid effect of the acid in producing healthy reparative action.—*Lancet*, June 4, 1870.

A Case of Syphilis treated by the Subcutaneous Injection of Bichloride of Mercury.—Dr. McEwen reports the

case of a man who complained of pains in the right elbow and the left shoulder, which were much worse at night. When first seen, November 12, 1869, they had existed two weeks. The case occurred in Dr. McCall Anderson's service, and this gentleman concluded that, as the man had a discharge and phimosis, and as there was no cardiac trouble nor sour sweats, it was a case of gonorrhœal rheumatism [*sic*]. The patient was treated locally with tincture of iodine to the joints, and an injection of sulphate of copper into the penis, and he took iodide of potassium internally; but the pain in the elbow remained. In about ten days the prepuce could be retracted, and then an indurated chancre in a cicatrizing condition was discovered, besides a macular syphilide which had so far progressed on the thighs as to be copper-colored, and there was inguinal adenopathy. He then had an injection every day of one eighth of a grain of the bichloride of mercury, which very soon entirely cured the articular pain, and caused the disappearance of the cutaneous manifestations.—*Glasgow Medical Journal*, February, 1870.

Chloral in the Neuralgias of Syphilis and Venereal Diseases.—Dr. C. Mauriac, physician to the Hôpital du Midi, has lately tested the value of hydrate of chloral as an hypnotic in these affections. The preparation of chloral used by him was in the form of capsules, which are made by Linousin, of Paris, each containing about five grains. The first case in which the remedy was employed was one of very severe nocturnal rheumatoid pains and cephalalgia. The pain was so severe as to prevent the patient from sleeping more than two or three hours in the night. Chloral, in doses of about twenty grains, was given, and, though it produced a quite prolonged sleep, yet its use was finally discontinued, as it always caused a heavy, drowsy feeling, with throbbing at the temples during the day following its administration. It, however, in this case, did not produce gastric derangement. The second case was likewise one of nocturnal rheumatoid pains and cephalalgia from syphilis, and chloral was administered in the same dose as in the other case; and, though it alleviated the patient's sufferings, its use was discontinued on account of the heavy sensation at the epigastrium and colic which it produced. In the third case the remedy was used quite freely, as it was one with quite severe neuralgic symptoms; administered in the same dose, it always produced a grateful sleep, and was not followed by any unpleasant symptoms during the following day. In the mean time, a mercurial course was prescribed, and the pains

were radically cured. M. Mauriac thinks that this case proves the superiority of chloral over opium as an hypnotic in these cases. The remedy was also used with benefit in a case of virulent bubo, with single neuralgic complications. The patient, a man thirty-five years of age, had had syphilis ten years ago, and in March, 1870, had a virulent bubo following chancroidal ulcers. While the bubo was in a highly inflammatory condition, the patient was seized with very acute pain in the buttock and calf of the leg of the same side as the bubo; there being no connection between the two pains. There was no apparent lesion, and the pains were of a neuralgic character. Twenty grains of chloral were unsuccessfully administered, and the next night the dose was doubled, with the effect of producing nine hours' sleep. The same dose was then continued, with the intermission of only one day, until the bubo was in the reparative stage, when, as the pain had ceased, it was discontinued. When the patient did not take the remedy, sleep was impossible, in consequence of the pain. M. Mauriac thinks that a febrile movement, even if mild, interferes greatly with the hypnotic effects of the drug, and that the pain is not felt on account of the profound hypnotic effect produced, rather than that the drug assuages the pain. As regards the complication between the virulent bubo and pain in the buttock and calf, in his experience the case is unique; but he frequently has seen cases of neuralgia of the crural nerve complicating virulent bubo. The chloral was given in dram doses to a patient having a double blennorrhagic orchitis complicated with a crural neuralgia which was so intense as to prevent any sleep at night. The dose was continued every night for six nights, and at the end of that time the pain ceased to trouble the patient, who experienced no bad effects from such a large dose of the drug.

In a severe case of bi-temporal neuralgia, in a patient with early secondary syphilitic symptoms, chloral was given in dram doses with very good effect.—*Gazette des Hôpitaux*, June and July, 1870.

Treatment of Urethral Stricture.—Mr. James Paget, in a clinical lecture on this subject, first called attention to the beneficial effects of rest, warm baths, and opium in cases of stricture complicated with retention, and advised a delay in the use of the catheter in such cases. He presented, on this occasion, two cases, the first one of slight stricture, who, having retention, was relieved by rest, opium, etc.; the other was a slight stricture, complicated with perineal abscess, and having been treated for retention for three weeks without

catheterism, at the end of that time Mr. Paget passed a No. 6 sound easily. Mr. Paget compared the pathological condition of the urethral mucous membrane to that of the conjunctiva and nasal membrane which become chronically inflamed and thickened, and in the urethra produced the symptoms of incontinence and retention, as formidable as those of organic stricture. This spasmodic condition and swelling, which narrow, or temporarily obliterate the calibre of the canal, are best treated by an unstimulating diet, rest, warm baths, alkalies, etc. As regards perineal abscess, Mr. Paget said that that was the result of inflammation of the tissues surrounding the urethra, and not of ulceration. Mr. Paget then spoke of the peculiar morbid sympathies of the urethra, the first, syncope from the passage of a catheter, the next, epileptiform convulsion, both of which Mr. Paget thinks never occur unless the patient stands up. The third peculiar sympathy is rigor, which generally occurs in patients who have never previously been catheterized, but usually comes on at the first passage of urine after the operation. This complication is said to be most frequent in persons who have malarious disease, or who have lived in a tropical climate, and the rigor resembles that of intermittent fever. Death had, in his experience, been known to follow in six cases, though the rigor is not generally a serious symptom, either after catheterism or lithotomy or lithotripsy. This complication may be avoided by alcoholic stimulants after the operation. A fourth complication is pyæmia, which has been known to occur after catheterism, without any injury to the urethra, or urinary infiltration. Mr. Paget alluded to the curious relation between the urethra and other parts, the condition known as gonorrhœal rheumatism, which, by some, is regarded as pyæmic. Mr. Paget thinks that any inflammation of the urethra, whether or not specific, may be accompanied by this complication. Attention was then called to the coincidence of scleritis, urethritis, and effusion into joints, and Mr. Paget thought that they were more frequently gouty than rheumatic.—*British Medical Journal*, April 2, 1870.

Treatment of Stricture of the Urethra.—Professor Mitscherlich, of Berlin, states that for years he has treated urethral stricture by dilatation with whalebone and elastic bougies, and that the time usually required is from four to eight weeks, and that by this method, years after, usually no recontraction can be discovered. In very tight, almost impassable, strictures, he uses horse hairs, by which he has, in the most difficult cases, reached the bladder. Horse-hair bougies are serviceable

from their very minute size, their solidity and elasticity, and from the fact that they do not injure the urethral walls. Dr. Mitscherlich uses the hairs from the horses' tails, cuts them of an appropriate length, and in cases where greater calibre and solidity is required, he glues several together with an elastic varnish. Having introduced the horse-hair bougie as a conductor, he slides upon it an elastic bougie open at either extremity, with a diameter of less than half a line, and a uniform calibre its whole length. Carefully introduced, the horse-hair insinuates itself into the narrowed and sinuous course of the urethra, without producing irritation, or making false passages. Dr. Mitscherlich reports a case of venereal catarrh, with great urethral irritability, resulting from an old stricture, in which he finally succeeded in using large sounds. The horse-hair bougies may be retained in the urethra several days without producing any irritation, and Mitscherlich refers to nine cases, of which eight were cured by this procedure, while the other case did not continue the treatment. In a case of very tight traumatic stricture, which is generally considered very rebellious to treatment by dilatation, Mitscherlich succeeded in producing a full calibre of the canal, so that very large sounds could be readily passed. Mitscherlich thinks that his treatment is worthy of adoption, by reason of its simplicity and the certainty by which strictures, when, if otherwise treated, impassable, can be dilated, thus avoiding the severe operations of external and internal urethrotomy.—*Archiv für Klinische Chirurgie*, XI. Bd., 2 Heft.

Puncture of the Tunica Albuginea in Parenchymatous Orchitis.—Dr. M. Beltz, of the Hospital Teniet el-Haad in Algeria, criticises the views of Salleron upon this subject, a résumé of which appeared in our last number. M. Beltz thinks that Salleron's conclusions adverse to the propriety of the operation are based upon a too limited experience, the latter having reported but two cases which resulted badly, one of which was recounted to him orally twenty years after its occurrence, the other personally observed. Beltz thinks that Velpeau's opinion, that there is danger of extrusion of the testicular substance when the testis is punctured in a healthy state, is perfectly correct, and of course that Salleron's opinion to the contrary is wrong. He thinks that the enlargement of the organ is due to the effused serum being lodged and held between the seminiferous ducts in the meshes of the connective tissue, and that puncture simply causes the expulsion of this serum and not of the substance of the testis. He thinks that

the trabeculæ are not softened, at least in the first day or two of the disease, and that the seminiferous substance is firmly held in its envelope; but that later, on about the eighth day, this softening may occur, and then, if the operation is performed, hernia of the contents of the tunica may occur—this, he thinks, proves that the operation, to be successful, should be done early, and not delayed at all. He thinks that, had Salleron's first case been operated upon on the second instead of the eighth day, its result might have been different. As regards the second, as it was a mere recital twenty years after its occurrence, it is unworthy of scientific consideration. M. Beltz thinks that Salleron's assertion that puncture of the tunica albuginea has no power in preventing suppuration and gangrene of the testis, because the strangulation takes place at the corpus Highmorianum, is wholly incorrect. The latter body being merely a thickening of the tunica albuginea, its puncture at any part relieves strangulation, and is not comparable to an operation for strangulated hernia by opening the sac, rather than of relieving the constriction. Beltz reports four cases of parenchymatous orchitis thus treated, in all of which the patients experienced immediate relief to their sufferings, there being no bad result, except an adherence between the serotum and testis by the cicatrix in one case. He cites besides, a good result in the person of a patient at the clinic of Professor Schützenberger, of Strasbourg, and besides this, mentions M. Adolphe Richard's unqualified approval of the operation in his hand-book on surgery. Far, then, from Vidal having, as supposed by Salleron, some unknown means of operating, or some peculiar happy luck, others have good results from the operation. M. Beltz thus summarizes his conclusions:—

1. That puncture of the tunica albuginea, an operation of incontestible utility, and rarely dangerous, may be followed by atrophy of the testis, as Salleron shows.

2. That the bare possibility of this accident ought to render the surgeon chary in the employment of the method, and only to use it in very severe cases.

3. That it is *always* necessary to operate at the invasion of the disease, and that it is prudent to forewarn the patient of the possibility of atrophy of the testis.—*Gazette des Hôpitaux*, June 4, 1870.

Treatment of Blennorrhagic Orchitis by Puncture of the Tunica Vaginalis.—Drs. Leone Ragazzoni and Odoardo Appiani have treated many cases of blennorrhagic orchitis in hospital practice by puncture of the tunica vaginalis. They

regard it as a rational operation, and state that it always is successful in their hands, and never has been attended by any bad results. They say that the relief is manifest immediately, and that though the testis swells more the first day after the operation, this rapidly subsides, and a cure is effected in about eight days. They detail twelve cases thus treated.—*Giornale Italiano delle malattie veneree e delle malattie della pelle*, Anno V., Fascienlo 6.

The Subcutaneous Treatment of Buboës.—Dr. Tomowitlz contributes the following facts and conclusions in regard to Grünfeld's method of treating buboës by pumping out the pus. Fifty cases were treated by the above-named method; twenty-seven of them were treated by the simple use of the syringe, without subsequent injection of fluid at any time. In the remaining cases, supplementary surgical interference—incision, or ablation of undermined integument—was necessary. Of the whole number of cases treated, undertaken indiscriminately, some gave reason to anticipate an untoward result, as not allowing of approximation of the integument, or from subsequent disturbance of its relations, etc. In the twenty-seven cases successfully treated by the use of the pump, the duration of the treatment, reckoning from the day of puncture to the complete cohesion of the walls of the abscess, was

In	8 cases,	.	.	.	.	.	.	From	1 to 10 days.
"	12	"	.	.	.	.	.	"	10 to 20 "
"	5	"	.	.	.	.	.	"	20 to 30 "
"	2	"	.	.	.	.	.	"	30 to 40 "

The shortest period of treatment was five days, and the longest thirty-five. The author thinks the result would have been more favorable, but for the fact that in most of the cases he resorted to the knife too early. He thinks Grünfeld's statement, that even the *last drop* of pus can be withdrawn by means of the syringe, a little overdrawn. The painlessness of the operation constitutes one great advantage; the others consist in the short duration of the treatment, in its not leaving a scar, and in the prevention of nosokomial gangrene.—*Wien. Med. Presse*, X., 40, 1869; *Schmidt's Jahrbücher*, June, 1870, p. 278.

The Treatment of Acute Orchitis.—Mr. J. Rouse, assistant surgeon to St. George's Hospital, while reprobating the usual methods of treating acute orchitis, proposes one which certainly has the merit of simplicity. He commences by giving a dose of senna so as to produce a brisk purgation, then he gives a grain of opium every morning and night, and envelops the in-

flamed organ in warm fomentations of Goulard's water and landanum. He states that he has arrived at this simple method after duly trying all others, and that this has always succeeded except in one case, which was that of an out-patient, who, while laboring under orchitis had to do heavy work, and, as the inflammation was very intense, one grain of calomel was added to each pill, with the effect of controlling the pain and inflammation, and effecting a cure in two weeks; whereas the usual time Mr. Rouse generally calculates upon is one week. The immediate effect of the opium is to relieve pain and render the patient comfortable, and the swelling then gradually subsides. Before using opium alone Mr. Rouse had, as routine practice, given two grains of calomel and one of opium twice a day; but the observation of a case which had been very much aggravated by mercurials induced him to give that agent up. Mr. Rouse objects to antimonials, as they produce nausea, and a patient having orchitis generally has some gastric disturbance. Local blood-letting he thinks also unadvisable; it is unnecessary, and is often followed by troublesome hemorrhage. Mr. Rouse prefers the puncture treatment of Mr. Henry Smith to either calomel or antimony, but still does not think it a necessary procedure; as to strapping, he thinks that, as it requires to be done often, and as it always produces pain, it is objectionable. When the pain has subsided and the swelling is decreasing Mr. Rouse gives his patient twenty drops of the muriated tincture of iron three times a day.—*St. George's Hospital Reports*, vol. iv., 1870.

Acute Spinal Paralysis cured by Anti-Syphilitic Treatment.—This case is recorded in the *Med. Centr. Zeit.* of Berlin, and is remarkable for the clear syphilitic history. An officer, aged thirty-five, after going through a mild syphilis, had a gummy tumor over the first dorsal vertebra, which caused some stiffness of the neck. This tumor became less, and almost disappeared in a twelvemonth, when another formed on the skull, at the junction of the left frontal and parietal angles. It became large and was painful; walking became difficult, and paralysis of the arms set in. A mercurial treatment, coupled with the use of galvanism to the affected limbs, restored him completely.—*Lancet*, July 2, 1870.

A new Retentive Catheter.—Mr. Richard Day exhibited to the Medical Society of London a new form of retentive catheter, which possesses the essential qualities required for general use, viz.: ease of introduction, of retention, and withdrawal. It consists of a French vulcanite catheter through

which a string is passed, emerging at a clean hole an inch and a half from the point, and then bridging over the usual opening for the urine, is inserted securely at the point. The opening for the urine is punched one inch from the point, and is on the opposite aspect of the tube to the usual hole. The handle consists of a leathern collar with a slot in it, a knot in the string and a plug on it. In order to introduce it fix it on a long stilet, oil and pass into the bladder. Then in order to retain, draw the string at the handle, fix the knot behind the slot, and use plug or not at discretion. The effect of this is to reduplicate the terminal three-fourths of an inch of the catheter so that No. 12 in the urethra becomes No. 24 in the bladder. When it is desired to withdraw the instrument slip the string out of the slot and the tube by its elasticity restores the end to its original size. To compare this procedure to an anatomical simile is to suppose the end of the catheter to be a finger, and the string a flexor tendon, and the elasticity of the tube to be the extensor.—*Lancet*, April, 9, 1870.

Syphilitic Affections of the Eye treated by the Hypodermic Injection of Calomel.—Professor Quagliño and Dr. Soresina report a considerable number of cases of various ophthalmic diseases of syphilitic origin in which this treatment has proved successful. Among others are: a case of complete paralysis of the third nerve of the right side; a case of punctated keratitis with iritis; a case of retino-hyaloiditis with syphilitic complication, etc. The calomel was sometimes injected hypodermically into the temples and sometimes in the arms, and always with great benefit. The advantage of this treatment was particularly well shown in cases of serous iritis, and also in cases of the plastic form with posterior synechia and tendency to occlusion of the pupil, the dilatation of the pupil and the breaking down of the adhesions being effected with comparative facility.—*Giornale Italiano delle malattie veneree* and *Practitioner*.

Ulcers of the Legs, probably Syphilitic, cured by local Calomel Fumigation.—Mr. Pick, of St. George's Hospital, reports the case of a girl, who soon after her birth had had spots about the anus and thrush. [*Sic.*] The child's parents were healthy and denied having had syphilis, and other children by them were healthy. In the present patient, who is now about six years old, there is slight notching of the lower incisors, and on both legs she has large circular ulcers which almost encircle them and occupy their middle third, and have undermined and everted edges. Some of them contain sloughs, and in others the

base is formed by dead bone, around which there is considerable periosteal thickening. The skin in the vicinity is of a brick-red color with purple, and white shining cicatrices are seen in the neighborhood. She had been treated in the same hospital during the last four years eight times, and the ulcer had never been entirely healed. Mr. Pick thought that the lesions were those of hereditary syphilis, and determined to try the effects of local calomel fumigation. To this end her legs were exposed every night to the fumes of twenty grains of calomel. The ulcers began to look healthy and to cicatrize immediately, and in about twenty-eight days they had thoroughly healed. Her gums had become slightly tender, but she gained considerable flesh.—*Lancet*, April 2, 1870.

On Iodide of Potassium and the Alkaline Sulphites.—Dr. McCall Anderson thus formularizes the indications for the use of iodide of potassium:—

1. The longer the interval which has elapsed between the syphilitic contagion and the appearance of the eruption, the more likely is it to be of service.

2. If the patient is cachectic it is more beneficial than mercury, except in the early stages of syphilis, when the mercurial vapor bath or other treatment proves more successful.

3. The more extensive the tertiary eruption the more certain is it that it will yield to the iodide.

4. If there is any tendency to syphilitic disease of the nostrils or neighboring parts, it should be withheld or cautiously given, for it produces coryza, and is very apt to aggravate the case.

5. It should always be given in large doses, not less than ten grains, and even as much as thirty or forty, three times a day. It is generally well to prescribe it in a bitter infusion, and in cachectic subjects to combine it with iron.

The alkaline sulphites and hyposulphites have been proved to be efficacious in certain furunculoid affections. Impressed with the results of Dr. Ricci's experiments with these agents, and thinking that an impure state of blood is the cause of these recurring troubles, Dr. Anderson has carefully used them, and in some instances with very good results. He reports the case of a young man who had successive and copious crops of furuncles, who took half a dram of the hyposulphite of soda twice a-day, and was entirely cured.

Attention should be paid to the general condition, particularly of the bowels, before administering these remedies. They should always be given largely diluted, as in the following prescription.

R—Hyposulphite Soda,	. . . . .	$\frac{7}{8}$ iss.
Simple Syrup,	. . . . .	$\frac{3}{4}$ j.
M—Cinnamon water,	. . . . .	$\frac{3}{4}$ ixxx.

A tablespoonful in a large wine-glass of water thrice daily on an empty stomach.

Dr. De Ricci prefers the sulphite of magnesia as it is more palatable, does not produce diarrhœa, and contains more acid than the other salts. He cites a case of chronic pemphigus in an old gentleman in which it produced a cure. Dr. Anderson thinks that these remedies are worthy of an extended trial.—*Lancet*, June 25, 1870.

Some Points in the Treatment of Lupus.—Dr. Tilbury Fox positively denies the strumous origin of lupus, but thinks that, when it occurs in strumous subjects, there is an unusual tendency to ulcerate, to produce considerable quantities of pus, and to crust very freely. He has also observed that some patients having lupus tuberculize rapidly, and he believes that the phthisical cachexia rather than the strumous is allied etiological to lupus. Dr. Fox does not think that lupus erythematosus originates in the sebaceous follicles, but that any disease of those organs is secondary to change in the other parts of the skin. He doubts whether benefits are derived from the usual routine treatment, regarding internal treatment as in many cases powerless, and very active interference in others as being baneful. He thinks that the nature of the morbid changes which take place should indicate the line of treatment rather than base it upon external appearances. In lupus there is new tissue formation and increased blood supply, the results of which are either absorption, or ulceration and cicatrization. His rule is, when the ulcerative process is active, to examine carefully for strumous taint, and if he has cause to suspect it he uses iodine, iron, and cod-liver oil. He has lately used the ioduret of iron in gelatine capsules, and regards it as superior to Blanchard's pills. The aim of the medication is to remove any unfavorable influence a strumous condition may impress upon the lupus. He regards syphilis as very often a complicating condition of lupus, and details an unmistakably plain case of tubercular syphilide which he cured by a mixed treatment. He thinks that the difference between the tubercles of syphilis and those of lupus is that the former are vascular, while the latter are not. In those cases which come under his observation, in which tuberculosis rapidly develops, he freely uses cod-liver oil. He doubts whether arsenic has any influence upon the disease. Though Dr. Fox places great reliance upon local treatment, especially

by caustics, he insists upon the fact that there is a time when that method should not be used, and others when it can be beneficially employed. For instance, in the early stage of lupus erythematosus when there is marked congestion, heat, and tenderness, he thinks that caustics only aggravate the condition, whereas mild applications answer admirably. He always uses a lotion of calamine with prussic acid and glycerine. When the congestive stage is passed, the use of caustics is admissible. He advises at first the trial of a mild application, such as the emplastr. hydrargyri in case there are well-defined tubercles without tendency to extend. As a stronger caustic he uses equal parts of caustic potassa and water, which is to be brushed on and followed by a poultice or bland ointment. The spreading and tubercular forms he cauterizes with the acid-nitrate of mercury, or with the nitrate of zinc paste, of which the following is the formula:—

R—Nitrate of zinc,	. . . . .	3 iss.
Distilled water,	. . . . .	3j.
Glycerine of starch,	. . . . .	3j.
M—Wheat flour,	. . . . .	3j.
Make a paste.		

According to this formula the zinc is in the proportion of one to three, which may be increased to one to two in severe cases. The parts are covered with this paste, and if pain is produced a poultice is applied, and the raw surface dressed with zinc or lead ointment. When the sore has dried up or crusted over, the caustic may, if necessary, be reapplied. In those cases in which dark crusts form, and there is considerable discharge, a very successful plan is to remove the scabs by a poultice, and then dress the surface with an ointment of the pyroligneous oil of juniper, of the strength of one dram to the ounce. If the ulcer spreads, the nitrate of silver should be freely applied. Dr. Fox prefers, in the exedent form of lupus, arsenical and zinc caustics. His method of treatment may be thus summed up. He endeavors to relieve congestion and tenderness by the calamine lotion, and to stimulate with the ointment of pyroligneous oil of juniper, and if possible, produce healthy granulations, and he says, that the careful adjusting of these remedies has given him good results in the treatment of his cases.—*Practitioner*, September, 1870.

Treatment of Lupus Erythematosus by Lemon Juice.
—Dr. Wardell, of the Tunbridge Wells Infirmary, reports the case of a healthy girl, aged twenty-three, who had had a patch of lupus erythematosus upon the face since infancy. She had been treated by various remedies, but without benefit. She

was ordered to take the juice of three lemons daily, and also some cod-liver oil. The result was an immediate improvement in the appearance of the patch, which has since continued. Dr. Wardell has also had a similar patch upon the face of a middle-aged woman, which had existed six years, and which got entirely well under the lemon-juice treatment.—*Lancet*, Sept. 3, 1870.

Treatment of Lupus Erythematosus.—Dr. Geddings recommends that the scales should be removed by the application of strips of linen soaked in oil, and kept in position by a flannel roller. The diseased parts are then to be rubbed with a good lather of potash soap on flannel. This failing, strong *liq. ammoniæ* or strong *liq. potassæ*, with a peneil of lint, or a solution of iodine and glycerine as follows:—

R—Iodinii	gr. xx.
Glycerinæ	3j.
M—Potassii iodidi	3 ss.

In other cases Roehard's ointment may be used. The following is the formula for its preparation:—

R—Hyd. submur.	gr. xx.
Iodinii	gr. viij.
Melt together with the aid of gentle heat, and triturate with	
M—Ung. conii	3 ij.

Carbolic acid has been used externally with varying success, whereas arsenic, mercury, and cod-liver oil are generally of no benefit.—*American Journal Med. Sciences* and *Journal Cutaneous Medicine*, No. 14, 1870.

The Internal Use of Glycerine in Acne.—Reasoning upon the definite mode of elimination of remedies by certain organs, and that fatty substances are eliminated by the sebaceous follicles, M. Gabler has endeavored to verify the hypothesis clinically. A young girl having acne punetata, which had resisted other methods of treatment, was treated by the internal use of glycerine in doses of two dessert-spoonfuls per diem, in hope that this substance, so analogous to oils, would, like them, follow the ordinary modes of elimination, and, in traversing the sebaceous follicles, would modify their secretion and render their contents more fluid. The result supported the theory, for, from the day that the remedy was first taken, the pustules diminished in volume and number, and soon disappeared altogether. The bowels, which had previously been costive, were rendered open and regular, though the glycerine did not act as a purgative. M. Gabler suggests the use of glycerine in cases where cerumen has accumulated in the ear.—*Lyon Médicale* and *Practitioner*, September, 1870.

New Instruments.

A NEW FORM OF SELF-RETAINING CATHETER FOR THE BLADDER.

MR. BARNARD HOLT proposes a catheter which may be retained in the bladder, and which has not the objectionable features of other instruments. It is made of vulcanized india-rubber, and has on either side a wing or fin of the same material, which prevents its escape from the bladder. The catheters are made of various sizes, and are perfectly smooth. The mode of introduction is very simple : Place the catheter upon a strong stylet with a handle, and stretch it so as to make it as small as possible, then, having oiled it well, press the wings against its sides and gently introduce it into the bladder. The end of the catheter may be cut off about an inch from the meatus, and its lumen stopped by a simple peg or a metal stop-cock. The

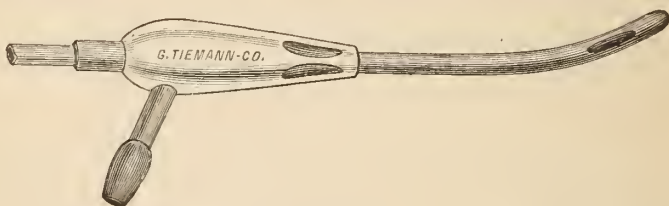


patient should be kept quiet for the first twenty-four hours after, to allow the bladder to become accustomed to the instrument, and in order to prevent its being grasped by the bladder the whole of the urine should not be withdrawn at once. Especial care should be taken that the catheter does not become entangled in the clothes as it might be violently withdrawn, and also that the urine should not be retained until there is very urgent desire to void it, as the instrument may be expelled with it; this, however, is not likely to occur in cases of atony of the bladder or of enlarged prostate. The patient should be directed to gently irrigate the bladder with tepid water every day, and thus prevent inerustation and occlusion of the eyes of the catheter by mucus. As long as neither pain nor frequent

desire to urinate are produced, the instrument may be retained, but it should as a rule be removed once a fortnight. Mr. Holt particularly remarks that the instrument is not applicable to cases of difficult stricture. The advantages claimed for the instrument are: First, that it is self-retaining and does not require adjustment by tapes or any other contrivance; second, that it produces very little if any irritation, and from its flexibility may be worn by the patient while at his daily duties; and third, that it is not acted upon by the salts of the urine.

A NEW INSTRUMENT FOR IRRIGATING THE URETHRA AND
BLADDER.

DR. RELIQUET has devised an instrument which obviates some of the difficulties heretofore experienced in irrigation of the bladder. This instrument has lately been made in this country by Messrs. Tiemann & Co., and we give an illustration and description of it. The body of the instrument, which is made of



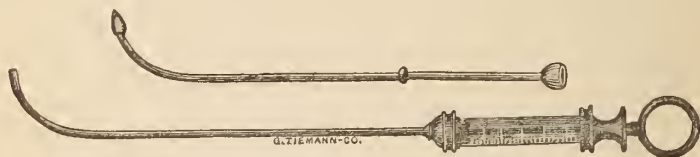
German silver, consists of a slightly conical-shaped tube or funnel, upon the base of which and continuous in a direct line with it is a smaller tube; near the apex of the funnel are three oval *fenestræ*, their long diameter being in coincidence with the long diameter of the funnel, and occupying the distal third of the tube. From one side of the base of the tube a smaller tube springs, and passes off at an obtuse angle and ends by a dilated flange. This branch tube is about three-quarters of an inch in length, while the tube itself is about an inch and a third. The mode of application of this instrument is as follows: a very flexible gum-elastic catheter of a size of about No. 3 or 4 of the English scale is to be passed into the attenuated continuation of the funnel, until it passes through the apex; then it is slid along the catheter near its open end, which should be provided with either a metallic or ivory funnel, into which the nozzle of the irrigating syringe is to be inserted, and which it should closely fit. The catheter should also accurately fit either extremity of the tube, which are of the same size, and should be

carefully oiled and slowly passed into the bladder. Before introduction a tube of flexible india-rubber should be slid over the flange upon the smaller tube, and this will conduct the return current of fluid into a proper vessel for the purpose. When the catheter is in the bladder the base of the tube is clasped by the lips of the meatus and prevents any escape in that direction; then the irrigating instrument, whatever the surgeon may choose, is attached to the funnel at the end of the catheter, and the fluid flows into the bladder, then returns through the urethra along the sides of the small catheter, then, through the *fenestræ* in the sides of the apex of the tube into the bifurcation already described, into the vessel placed for its reception. The tubes are made of different sizes at their bases so as to fit the varying calibres of different meatuses. The usual rules for irrigation of the bladder are to be followed. If we wish merely to wash out the deeper portions of the urethra it is not necessary to introduce the catheter fully into the bladder; and if we desire to irrigate the latter viscus, we of course introduce the catheter into it. If resistance is offered to the passage of the catheter by spasm about the membranous portion of the urethra it is then necessary either to place the patient in the usual position for catheterism or that he should stand upright and relax the perineal muscles by making the usual efforts at urination. The application of the instrument is, of course, in cases of atony of the bladder, in enlarged prostate, and in abscess of the prostate, particularly in cases in which tubercles deposited in that organ had softened and left pus secreting caverns.

AN INSTRUMENT FOR INJECTING DEEP PORTIONS OF THE URETHRA.

DR. R. W. TAYLOR, of the New York Dispensary, proposes a modification of Bumstead's syringe for injecting the deep portions of the urethra. It consists in a hard-rubber tube about six inches long, having a slighter curve than the short one of Thompson, at the end of which is an acorn-shaped bulb or head. This bulb is perforated upon its tapering sides by twelve very minute holes which are arranged in four rows of three holes each, placed equidistantly around the head. The apex of the bulb is somewhat rounded, so that in introduction the folds of urethral membrane are not wounded; its base also rounds off and presents a shoulder before it merges into the shaft. The tubes are made of various sizes, corresponding to Nos. 4, 6, 8, and 10 of the English scale, while the widest portion of the bulb is two sizes larger than the shaft. There is

also a button of hard rubber which slides upon the shaft, by means of which precision of injection is attained. The advantages claimed for this instrument are, that there is no regurgitation of the injection as its return is prevented by the shoulder of the bulb, whereas, in the old instrument, the extremity was only slightly larger than the shaft, and while it did not distend the urethra and thus bring the injection into contact with the whole surface, it allowed it to return along the sides, which is extremely objectionable when strong solutions of the nitrate of silver are used. Another advantage claimed, is, that the smallness of the holes presents a resistance to the expulsion of the fluid, and thus only a few drops may be thrown out, whereas, with the large single hole of the old instrument, a quantity of the injection was easily expelled, even when the surgeon endeavored to throw but a few drops. Then, with the



acorn-shaped bulb, the urethra may be explored, and if there are any slight contractions behind which pus is formed, or tender spots due to granulations, the bulb reveals them. To be certain that the injection is thrown precisely at the seat of disease, the latter may be localized either with the endoscope or by another acorn-shaped bongie, and the measurement can be accurately adjusted by the sliding button on the shaft, which is to be gently pressed against the meatus. When used in the deepest portions of the urethra the instrument may be introduced fairly into the bladder, which fact is known by slightly rotating the shaft, and then withdrawn to the desired spot. The instrument thus modified has none of the dangers of the old Acton syringe, and is capable of more extended and easy application than that of Lallemand. It is made by Messrs. Tiemann & Co., of New York.

Obituary.

JAMES SYME.

THE medical profession of the city of Edinburgh, and of the world at large, while yet grieving for the death of Sir James Simpson, has been called upon to bear the loss of the great man whose name heads this article. How great the loss is, we are scarcely yet in the position to realize.

James Syme was born in Edinburgh, on the 7th of November, 1799, and died in the city of his birth, and on the field of his great career, on the 26th of June, 1870. He received his academic education at the High School of Edinburgh, and in his years of boyhood devoted much of his attention to the natural sciences. Adopting the profession of surgery, he threw into its study and practice the whole energy of a gigantic mind, and made himself one of the foremost of the immortal men who, during the past half century, have contributed so powerfully to raise the art of surgery to the proud position which it now holds. If Mr. Syme had never conceived and carried forward the various operative procedures with which his name is associated, but had contented himself with teaching surgery in his own brilliant way, his name would have been illustrious; but his original feats in practical surgery have given him a claim to one of the highest positions among the benefactors of mankind. The more noticeable of these achievements were briefly as follows:—(1.) His championship of the resection of large joints, particularly the shoulder, the elbow, and the knee, as a procedure whereby amputation may often be avoided, and as a means by which countless limbs and lives have been saved, and untold suffering prevented; (2.) the invention of the amputation at the ankle-joint, which is known by his name, and the value of which, as an addition to the resources of surgery, can scarcely be over-estimated; (3.) his operation of external division of the urethra for stricture by means of the shouldered sound; (4.) his bold and brilliant method of operating for the cure of traumatic and other aneurisms not admitting of the usual Hunterian operation.

Mr. Syme's earlier years of professional life were a constant struggle against immense odds, and his energetic, combative

temperament, which forced him to make war against the champions of error, as much as against error itself, gave a turn to his subsequent life, which earned him in some quarters the reputation of being quarrelsome, but which never got the uppermost of a kindly heart and a desire to assist his brethren by any means within his power.

In the beginning of his career he had the disadvantage of having to contend against the enmity of Liston, which long deprived him of a hospital appointment. This he overcame by the most extraordinary efforts, and subsequently was well crowned with honors. He gained the honorary degree of M. D. from Dublin and Bonn, and the degree of D. C. L. from Oxford.

His published works include a treatise on the "Excision of Joints;" a work on the "Principles of Surgery;" "Researches on the Function and Powers of the Periosteum;" a work on "Diseases of the Rectum;" and finally his collected "Contributions to the Pathology and Practice of Surgery." He was a frequent, but not voluminous contributor to the journals. His writings all show forth abundantly the searching, comprehensive attributes of his mind; but it was especially by his oral clinical teaching that he most impressed upon the surgery of his time those attributes which his own fertile genius had so well worked out.

AUZIAS-TURENNE.

THE pioneer in the doctrine of the curative and prophylactic treatment of syphilis by oft-repeated inoculations of venereal matter, or, as he called it, syphilization, died in Paris, of pneumonia, early in June of this year, aged 59 years. Graduating as a doctor of medicine in 1842, M. Auzias-Turenne has since held the position of Professor, Curator to the Museum of the Jardin des Plantes, Chevalier of the Polar Star of Sweden, and author of several works, and among them one very peculiar and original, entitled, "*Les Virus au Tribunal de l'Académie et dans la Presse*," and another upon hydrophobia. Early in his career he promulgated the doctrine of syphilization, urging its claims both as a prophylactic and curative treatment against venereal diseases. His theory has been attacked from its very birth almost to the day of his death in the most acrimonious manner, one strong point, in regard to which, however, he was silent during life, being, that he would not practice upon himself a treatment which he so persistently advocated for others. His doctrines, however, received as followers, Professor Sperino,

of the Syphilome of Milan, and Professor W. Boeck, of Christiania, and it is to the indefatigable labors of the latter gentleman that the world-wide dissemination of the doctrine is to be credited; though it is due to Dr. Boeck to say, that he only advocates the remedy as a curative, and considers its employment as a prophylactic as morally wrong. During the latter years of his life M. Auzias-Turenne has lived in comparative obscurity, and, according to all accounts, in poverty; but he has tenaciously clung to his doctrines, though he has had only occasional opportunity to practice his method upon patients, from each of whom he required a written certificate, that in the event of its not curing, or in any way being unsatisfactory to them, they would not resort to legal proceedings against him. He was always a peculiar man, having curious vagaries, and it is only last year that he proposed to intrust to the French Academy, a means of causing the dispersion of buboes, which was to be kept profoundly secret. Of late years he has contributed a paper upon vaccinal syphilis, and has been only occasionally heard of in connection with discussions upon syphilization. At his autopsy many characteristic cicatrices of inoculation were found upon his body, upon the sternum and legs, the sites of election for inoculations. There was, however, not found any lesion upon the penis, nor any trace of syphilis upon the body. So that his detractors, now, after his death, can but admit that he was in life consistent in his doctrines, and practised upon himself what he did upon others. In his will he desired a quiet interment, without any religious rites, and gave his body to his friend Dr. Boeck, desiring that it should be dissected, and that his skeleton should be carefully put together and deposited in the College of Christiania. He was an unbeliever in the doctrine of the resurrection of the body.

JOHN BACOT, F. R. C. S.

MR. BACOT died on the 4th of September, being 90 years of age. He commenced his studies at St. George's Hospital in 1798. He entered the Guards in 1803, and served until 1820, when he commenced private practice, and became surgeon to the St. George and St. James' Dispensary. In 1829 he published a work on syphilis. His treatise was quite popular at the time of its appearance. He was a member of the Senate of the University of London, and was also Inspector of Anatomy. He was made a member of the Board of Health in 1854. He leaves a son, an Honorary Deputy Inspector-General of Hospitals.

Editorial.

THE HALF-YEARLY COMPENDIUM OF MEDICAL SCIENCE.

A GREAT many readers are doubtless indifferent as to the source whence, and the manner in which, medical information is obtained by the journals; but to the careful, conscientious reader this is a matter of the greatest importance. A translator of an article is morally responsible to his readers that his rendering of his author is reliable and correct; the attachment of his name to the translation is a guaranty of its authentic character. In all cases where copies or translations are made for judicial or governmental proceedings it is even required that an affidavit should be attached to the copy or translation by the copyist or translator affirming the correctness of the copy or translation. Here there can be no mistake. In this way reliable information can be disseminated.

To condense concisely, and render in a clear, terse way into a paragraph or page a diffuse or elaborate article, requires, not only a good knowledge of the subject, but judgment and literary skill.

The editors of the *Compendium* profess a due appreciation of the services of translators and paragraphists, for, in their preface, they say: "It must not be forgotten that ours is a much more expensive enterprise than the republished foreign works of like character, *as we pay for all the literary work done on it*, besides issuing it in good readable type, on good paper."

But how do their professions tally with their practice? In Part VI., July, 1870, now before us, we find the following articles taken bodily from the pages of THE AMERICAN JOURNAL OF SYPHILOGRAPHY AND DERMATOLOGY, without the slightest acknowledgment, even among the list of authorities cited:—

ON STRICTURE, BY BUMSTEAD. ARTICLES ON THE TREATMENT OF PSORIASIS, BY McNAB, LIVEING, PASSAVANT, HARDY, AND SIMMS. ON THE TREATMENT OF ECZEMA, BY SPENDER. ON THE CONSTITUTIONAL TREATMENT OF SKIN DISEASES, BY McCALL ANDERSON. ON THE INFLUENCE OF SYPHILIS IN THE PRODUCTION OF TUBERCLE, BY LEBERT. ON THE TRANSMISSION OF SYPHILIS TO THE NURSING BY THE NURSE, BY DRON.

ON THE PATHOLOGY OF ECZEMA.

BOSTON, 10 PARK SQUARE, August 6, 1870.

M. H. ENRY, M. D.:—

SIR,—In your issue of July I showed that Dr. J. L. Milton's claim to priority in defining and publishing the well-known views of the Vienna school, with regard to the pathology of eczema, was ill-founded, and attributed this failure, on his part, to give due credit to Prof. Hebra, to "English conceit in such matters." In publishing my remarks you take occasion to say:—

"In regard to the priority of Hebra or Milton, in this matter, we have received the following communication from Dr. James C. White, of Boston. The letter may be perfectly correct so far as the statement goes that Hebra is entitled to priority in the publication of the views in dispute; but we have yet to learn that Dr. White is privileged, or in a position, scientifically, to speak of English dermatologists as he does."

I make no comment on this somewhat superfluous editorial personality, nor do I think it necessary to offer evidence as to the correctness of my judgment in a matter based on historical record. Such claims on the part of English men of science, and especially among medical writers, are too well-known to those familiar with the history of modern inventions and discoveries. To English dermatologists in general, no especial reference was made in my remarks. As to Dr. Milton in particular, I was unwilling to believe that he could be so ignorant of the history of the progress of dermatology as not to know a fact familiar to others, and preferred to refer this somewhat oblique view of dates to that well-known national trait, which has so often prompted his countrymen to assign to themselves the most important share in modern scientific discoveries.

In conclusion, allow me to express my surprise that any connection should be supposed to exist between a correspondent's "scientific position" and his "privilege" or ability to recognize a mental trait in the British nation.

I have the honor to be your obedient servant,

JAMES C. WHITE.

We publish the above at the special request of Dr. White. If we needed any additional evidence to prove the correctness of our views, it is certainly furnished in the above communication.

 THE NEW YORK DERMATOLOGICAL SOCIETY.

THE monthly meetings of the New York Dermatological Society were resumed on the 13th of September. The following gentlemen were elected members: Dr. F. N. Otis, Dr. Norton Folsom, Dr. L. D. Bulkley, and Dr. David L. Haight.

Bibliography.

LEÇONS SUR LE TRAITEMENT DES MALADIES CHRONIQUES EN GÉNÉRAL, ET DES AFFECTIONS DE LA PEAU EN PARTICULIER, PAR L'EMPLOI COMPARÉ DES EAUX MINÉRALES, DE L'HYDROTHERAPIE, ET DES MOYENS PHARMACEUTIQUES. Par le Docteur E. Bazin, etc., etc. Rédigées et publiées par E. Maurel. Paris: A. Delahaye. 1870. 8vo, pp. 467.

LA PROSTITUTION À PARIS ET À LONDRES 1789-1870, par C. J. Lecour, commissaire interrogateur, chef de bureau à la préfecture de la police. Paris: P. Asselin. 1870. Pp. 377.

THE PRACTICE OF MEDICINE. By Thomas Hawkes Tanner, M. D., F. L. S. Fifth American from the sixth London edition. Philadelphia: Lindsay & Blakiston. 1870. 8vo, pp. 1200.

GUIDE TO THE EXAMINATION OF THE URINE. By I. Wickham Legg, M. D. Second edition. Philadelphia: Lindsay & Blakiston. 1870. 16mo, pp. 89.

MANUAL OF CHEMICAL EXAMINATION OF THE URINE IN DISEASE. By Austin Flint, Jr., M. D. New York: D. Appleton & Co. 1870. Pp. 76.

A TREATISE ON THE THEORY AND PRACTICE OF OBSTETRICS. By William H. Byford, A. M., M. D. New York: William Wood & Co. 1870. 8vo, pp. 457.

THE RAISING AND EDUCATION OF ABANDONED CHILDREN IN EUROPE, ETC. By A. Jacobi, M. D., Pamphlet, pp. 43. 1870. From the author.

A CASE OF STRANGULATED OBLIQUE INGUINAL HERNIA REDUCED EN MASSE, ETC. By Erskine Mason, M. D. Pamphlet, pp. 15. 1870. From the author.

PERIODICALS RECEIVED.

Annales de Dermatologie et de Syphiligraphie. Deuxième année. No. IV. Paris, 1870. Archiv für Dermatologie und Syphilis. Jahrgang, 1860. Prag. Giornale Italiano delle Malattie Veneree e delle Malattie della Pelle, compilato e diretto dal cav. Dott. G. B. Soresina—to August, 1870. Edinburgh Medical Journal. June to September, 1870. Journal of Cutaneous Medicine and Diseases of the Skin. September. Vol. IV., No. 14. London: 1870. The Practitioner. The New York Medical Journal. June to September. The Journal of Psychological Medicine. American Journal of Insanity. July. The American Journal of the Medical Sciences. July, 1870. California Medical Gazette, June to September. Buffalo Medical and Surgical Journal. The Journal of the Gynæcological Society of Boston. The Medical and Surgical Reporter, Philadelphia. The Medical Record, New York. The Medical Gazette, New York. The Chicago Medical Times. The Medical News and Library, Philadelphia. The Pharmacist, Chicago. The Chicago Medical Examiner. Good Health—a Journal of Physical and Mental Culture, Boston. June to September.

Foreign books for review may be addressed to the following agents of the publisher, who will forward them immediately:—

LONDON.—Messrs. Williams & Norgate, 14 Henrietta Street, Covent Garden, W. C.

PARIS.—M. Cs. Reinwald, 15 Rue des Sts. Pères.

LEIPZIG.—Mr. L. A. Kittler.

INDEX TO VOL. I.

	PAGE
Abortion; Proportion of Abortions in Syphilitic Women. Weber.....	339
Acne Rosacea, Treatment of. Westerten.....	86
" Internal use of Glycerine in. Gabler.....	376
Actual Cautery in Treatment of Lupus. Anderson.....	184
Albinismus and Nigrismus. H. Beigel.....	136
Alcoholic Fomentation in the Treatment of Tinea Favosa. Cantoni.....	280
Alopecia Areata caused by Arsenic. Wyss.....	343
Amaurosis, Syphilitic. Galezouski.....	174
Analgesia of Secondary Syphilis. A. Fournier.....	64
Area Celsi. Rindfleisch.....	140
" Scherenberg.....	81
Arsenic as a cause of Alopecia Areata. Wyss.....	343
Arsenic by Hypodermic Injection, in Psoriasis and Chronic Eczema. E. Lipp.....	85
Arsenic in Herpetic Ophthalmia. Oglesby.....	86
Arteries; Acute Inflammation of Cerebral Arteries during Syphilis.....	72
ASSADORIAN, A. On the Treatment of Epididymitis by Sulphuric Ether...	216
<i>Atlas of Venereal Diseases</i> , by M. A. Cullerier. Review.....	47
Baths in Treatment of Skin Diseases. Anderson.....	177
BEIGEL, HERMAN. Albinismus and Nigrismus.....	136
" Papilloma Area-elevatum.....	70
Blennorrhagia, coincidence of Crural Neuralgia with. Coutagne.....	345
Blisters in Treatment of Skin Diseases. Anderson.....	184
BOECK, WILLIAM. On Syphilization.....	7
" Prostitution in relation to National Health.....	130
Brain, Syphilitic Disease of. Gay.....	330
Bromide of Potassium, Cutaneous Eruptions produced by. Voisin.....	80
Bubo. Auzias-Turenne's Treatment.....	91
" Subcutaneous Treatment. Tomowitlz...	370
Caoutchouc; its use in Treatment of Skin Diseases. Hebra.....	60
Carbolic Acid in Skin Diseases. Neumann.....	87
" in Syphilis. Kohn.....	364
" in the Treatment of Psoriasis. McNab.....	278
Carbolic Oil in the Treatment of Scarlatina. Smith.....	281
Catheter, New Retentive. Day.....	371
" " Holt.....	377
Caustics in Treatment of Skin Diseases. Anderson.....	183

	PAGE
Chancre; its Induration in the Female. A. Fournier.....	240, 322
“ Treatment of Complications. Gailleton.....	256
“ Urethral. E. L. Keyes.....	37
Choral in Venereal Neuralgia. Mauriac.....	365
Chromidrosis. A. W. Foot.....	76
Classification of Diseases of the Skin, Simplification of Hebra's. I. Neumann	327
Copaiba as a cause of Pemphigus. Hardy.....	79
“ in the Treatment of Psoriasis. Simms.....	279
“ Raquin's Capsules of.....	281
Creosote in Psoriasis. Balmanno Squire	86
Cubebs; Therapeutic Action. Heidenreich.....	90
CULLERIER, M. A. Review of his <i>Atlas of Venereal Diseases</i>	47
Dactylitis Syphilitica. Locke	151
Delhi Boil. Fleming	355
Derma, Relations of Epidermis to. Auspitz.....	351
Dermatalgia. H. S. Purdon.....	80
Dermatitis Toxicæ. Erasmus Wilson	81
Dermatology, Notes and Comments on. H. S. Purdon	21
DIDAY, P. Use of Ice in Affections of Testicular Apparatus	49
Digitalis in the Treatment of Orchitis. Besnier	278
Diphtheria following Measles. Fagge	78
Dystocia from Syphilitic Induration of Cervix. Putegnat	341
Eczema, Chronic, Treatment by Hypodermic Injections of Arsenic. E. Lipp.	85
“ in Aged Persons. H. S. Purdon.....	81
“ Marginatum. Review of Pick and Hebra's Discussion.....	40
“ Pathology of. F. Swift.....	93
“ Rubrum, Local Treatment of. Spender.....	279
“ Treatment. E. Wilson.....	84
Editorial. <i>Annales de Dermatologie et de Syphiligraphie</i>	87
“ <i>Journal of Cutaneous Medicine and Diseases of the Skin</i>	282
“ The Pathology of Eczema.....	282, 385
“ The New York Dermatological Society.....	283, 385
“ The Half-yearly Compendium of Medical Science.....	384
Electricity in Treatment of Hydrocele. Friedenthal.....	91
Elephantiasis Arabum, Treatment by Ligature. Fischer.	77
“ of Nose. Guibout	76
Endoscope, its use in difficult Strictures of Urethra. R. F. Weir.....	32
Epidermis, its Relations to Derma. Auspitz.....	351
Epididymitis, Treatment by Sulphuric Ether. A. Assadorian.....	216
Ergot in Treatment of Purpura. Bauer.....	87
Eruption, Cutaneous, due to Bromide of Potassium. Voisin.....	80
Erysipelas, Abortive Treatment of. Leuroth.....	86
Ether, Treatment of Epididymitis by. A. Assadorian.....	216
Eye, Syphilitic Affections of, treated with Hypodermic Injection of Calomel.	
Quaglino and Soresina.....	372

	PAGE
FOSTER, FRANK P. On Vaccino-Syphilitic Inoculation.....	199, 293
FOURNIER, ALFRED. The Analgesia of Secondary Syphilis.....	64
“ “ On the Induration of Chancres in the Female	240, 322
Fumigation with Calomel for Syphilitic Ulcers of Leg. Pick.....	372
Galvano-Cautic, Removal of an Encephaloid Sarcocoe by. Morpain.....	265
Gangrene of Penis. Demarquay.....	341
GAY, A. Syphilitic Disease of Brain.....	330
Glycerine, its Internal use in Acne. Gabler	376
Gonorrhœa, new method of Treatment by Injections. Durham.....	268
“ Treatment of. Black.....	263
“ Treatment of. Cullerrier.....	89
Gonorrhœal Affections of the Prostate. Erskine Mason.....	285
Hair, Post Mortem change of Color. Sonnenschein.....	77
HEBRA, FERDINAND VON. Rhinoscleroma.....	146
“ Use of Caoutchouc in Treatment of Skin Diseases	60
HENRY, M. H. Indications for Operative Interference in cases of Phimosis	118
Herpes, its occurrence during a course of Arsenic. Hutchinson.....	77
“ Epizooticus Contagiosus. Curgenvén.....	170
“ Zoster, Case of Third Attack of. Fox.....	354
“ “ Etiology. Hutchinson.....	77
“ “ of Face and Tongue. Ermerins.....	351
Histological Contribution. H. G. Piffard	217
Hydroa.....	353
Hydrocele, Treatment by Electricity. Friedenthal.....	91
Ice, its use in Affections of Testicular Apparatus. P. Diday.....	49
Ichthyosis, Local Treatment. Milton.....	88
Ichthyosis of Tongue. Paget.....	359
Impermeable Dressings in Treatment of Skin Diseases. Anderson.....	182
Impetigo, Contagious. Fox.....	164, 354
Injections in Gonorrhœa. Durham.....	268
Instrument for Injecting Deep Portions of Urethra. Taylor.....	379
“ for Irrigating Urethra and Bladder. Reliquet.....	378
Introduction.....	iii
Iodide of Potassium and Alkaline Sulphites. Anderson.....	373
Iodine in Treatment of Skin Diseases. Anderson.....	184
Keloid of Addison and Alibert. Hutchinson.....	173
Keratitis, Interstitial, with Syphilitic Iritis. Demarbaix.....	335
KEYES, EDWARD L. Case of Urethral Chancre.....	37
LANCEREAUX, E. On Syphilitic Fever.....	69
LEE, CHARLES C. On Congenital Syphilitic Pemphigus.....	205
Leprosy, Importance of Diagnosis of Leucoderma from White. Hutchinson.	253
“ in the United States. Holmboe	255

Leprosy, Treatment of. Bakewell.....	270
Leucoderma, Importance of its Diagnosis from White Leprosy. Hutchinson	253
Lice as a cause of Prurigo Senilis. Hutchinson.....	357
Lichen Planus. Erasmus Wilson.....	79
Liver, Syphilitic Inflammation of. Rodet.....	251
" Treatment of Syphilitic Waxy. Wetzlar.....	88
Lotions in Treatment of Skin Diseases. Anderson.....	178
Lupus, Treatment of. Fox.....	374
" Serpiginosus, Topical Treatment of. F. D. Weisse.....	316
" Erythematosus, Treatment by Lemon Juice. Wardell.....	375
" " Treatment of. Geddings.....	376
MASON, ERSKINE. On Gonorrhœal Affections of the Prostate.....	282
Measles and Scarlatina occurring conjointly. Ross.....	357
" followed by Diphtheria. Fagge.....	78
Meat Diet in the Treatment of Psoriasis. Passavant.....	278
Mercurial Applications in Treatment of Skin Diseases.....	180
Mercury, Treatment of Syphilis by Hypodermic Injections of. Van Mons..	90
" " " " " Diday.....	362
" " " " " Liégeois....	81
" " " " " McEwen..	364
" " " " " Quaglino & Soresina	372
Molluscum Fibrosum, Microscopic Appearances of. Fagge.....	350
Mucous Patches of Vulva and Anus. Soresina.....	339
Myelitis, Acute Syphilitic. Mollière.....	336
Nerve, Neuralgia of Crural, coincident with Blennorrhagia. Coutagne....	345
" Syphilitic Affection of Third, with Mydriasis and Ptosis. Withington	336
" Syphilitic Affection of Third. De Méric.....	168
" Syphilitic Paralysis of Seventh. J. R. Lane.....	337
Nerves, Termination of, in Epithelial Layer of Skin. Podcopaew.....	356
Nervous Symptoms depending on Intra-Cranial Syphilitic Disease. Jackson	159
NEUMANN, ISIDOR. A simplification of Hebra's Classification of Skin Diseases	327
Neuralgia, Venereal, Treatment of, with Chloral. Mauriac.....	365
Nigrismus, Albinismus and. H. Beigel.....	136
Nitrate of Silver in Treatment of Lupus. Anderson.....	183
Obituary. JAMES SYME.....	381
" AUZIAS-TURENNE.....	382
" JOHN BACOT.....	383
Œstrus Bovis, Parasitic Disease produced by Larva of. Walker.....	357
Ointments in Treatment of Skin Diseases. Anderson.....	177
Ophthalmia, Herpetic. Use of Arsenic. Oglesby.....	86
Orchitis, Puncture of Tunica Albuginea in Blennorrhagic. Salleron.....	260
" " " " " Nunn.....	262
" " " " " Beltz.....	368
" " " " " Ragazzoni and Appiani	369

	PAGE
Orchitis, Treatment by Antimonial Frictions. Michel.....	262
“ Treatment of Acute. Fry	263
“ “ “ Rouse.....	370
“ Treatment with Digitalis. Besnier	278
Palate, Ulceration of, in Young Subjects. Hutchinson	340
Papilloma Area-elevatum. H. Beigel.....	70
Paralysis, Acute Spinal, Anti-Syphilitic Treatment.....	371
Parasitic Disease produced by Larva of <i>Cestrus Bovis</i> . Walker.....	357
Parasiticides. Anderson.....	185
Pemphigus, Acute, from <i>Copaiba</i> . Hardy.....	79
“ “ following Chronic Gastralgia. Chatagnon.....	354
“ Congenital Syphilitic. C. C. Lee.....	205
“ Syphilitic.....	167
“ Treatment by Quinine. Dieren.....	88
Penis, Gangrene of. Demarquay.....	341
Phimosis, Indications for Operative Interference. M. H. Henry.....	118
Phosphorus in the Treatment of Psoriasis. Hardy.....	279
PIFFARD, HENRY G. Histological Contribution.....	217
Pityriasis, Lotion for. Hardt.....	280
“ Rubra. Benson and Smith.....	347
Potash Applications in Treatment of Skin Diseases. Anderson.....	179
Prostate, Gonorrhœal Affections of the. Erskine Mason.....	285
Prostitution in relation to National Health. W. Boeck.....	130
Prurigo. Tilbury Fox.....	347
“ Senilis, Lice as a cause of. Hutchinson.....	357
Pruritus of Pregnancy. Gros.....	87
“ Pudendi, Treatment of. Elleaume.....	79
Psoriasis, Treatment by Hypodermic Injections of Arsenic. E. Lipp.....	85
“ “ by Creosote. Belmanno Squire.....	86
“ “ with Carbolic Acid. M’Nab.....	278
“ Meat Diet in the Treatment. Passavant.....	298
“ Treatment with <i>Copaiba</i> . Simms.....	279
“ “ with Phosphorus. Hardy.....	279
PURDON, HENRY S. Notes and Comments on Dermatology.....	210
Purpura, Treatment by Ergot. Bauer.....	87
Quinine in Pemphigus. Dieren.....	88
Rectum, Syphilitic Stricture of. Marshall.....	186
Rhinoscleroma. Hebra.....	146
RINDFLEISCH. Area Celsi.....	140
Sarcocoele, Removal of an Encephaloid, by Galvano-Cautic. Morpain.....	265
Sarsaparilla in the Treatment of Syphilis. Allbutt.....	259
Scabies, Treatment of. Holmboes.....	88
Scarlatina and Measles occurring conjointly. Ross.....	357

	PAGE
Scarlatina, Carbolic Oil in the Treatment of. Smith.....	281
Scleriasis. Hilton Fagge.....	175
Scleroderma. Hilton Fagge.....	175
Skin Diseases, Constitutional Treatment of. Anderson.....	273
" Feigned and Hysterical. Startin.....	166
" Feigned. Fagge.....	349
" Notes on Treatment. McCall Anderson.....	176
" use of Carbolic Acid. Neumann.....	87
Skin, Ephemeral Congestive Tumors of. Perroud.....	76
" Gangrenous Affection of. Stockwell.....	356
" Termination of Nerves in Epithelial Layer of. Podcopaew.....	356
Small-Pox complicated with Urticaria. Gabler.....	355
Stricture of Urethra, use of the Endoscope. R. F. Weir.....	32
" Treatment. Bumstead.....	266
" " Mitscherlich.....	367
" " Paget.....	366
Sulphur in Treatment of Skin Diseases. Anderson.....	181
Sulphurous Acid in Syphilitic Ulceration of the Throat. Purdon.....	89
" " Ulcerations. Murchison.....	186
SWIFT, FOSTER. Pathology of Eczema.....	93
Syphilide, Papular. R. W. Taylor.....	105
" Serpiginous Tubercular. R. W. Taylor.....	23
Syphilis, Congenital. W. H. Van Buren.....	17
" the Doctrines of Unicism and Dualism of the Syphilitic Contagion.	
F. Zinsser.....	220
" its Transmission from Nurse to Nursling. Dron.....	247
" its Influence in Production of Tubercle. Lebert.....	157
" with Acute Inflammation of Cerebral Arteries.....	72
" Treatment by Hypodermic Injections of Mercury. Van Mons ...	90
" " " " Liégeois.....	91
" " " " Diday.....	362
" " " " McEwen....	364
" Treatment of. Barton.....	258
" Treatment of. Farquharson.....	259
" Treatment of with Carbolic Acid. Kohn.....	364
" Treatment of, without Mercury. Desprès.....	358
" Treatment with Sarsaparilla. Allbutt.....	259
" Treatment of, without Specifics. Œwre.....	360
" Treatment of, by Mercurial Suppositories. Lebert.....	363
Syphilitic Affections of Air Passages, Tracheotomy in. Trélat.....	82
" Affection of Third Nerve. De Méric.....	168
" Affections of Third Nerve, with Mydriasis and Ptosis. Withington	336
" Alterations of the Lung in the New-Born. Depaul.....	162
" Amaurosis. Galezouski.....	174
" Contagion, Duration of Power of. Drysdale.....	340
" Creeping Paralysis. Bayer.....	281
" Dactylitis. Locke.....	151

	PAGE
Syphilitic Disease, Intra-Cranial. Jackson.....	159
“ Disease of Brain. Gay.....	330
“ Fever. E. Lancereaux.....	68
“ Hepatitis. Rodet.....	251
“ Induration of Cervix Uteri as a cause of Dystocia. Putegnat...	341
“ Iritis with Interstitial Keratitis. Demarbaix.....	335
“ Myelitis, Acute. Mollière.....	336
“ Neuralgia. Use of Chloral. Mauriac.....	367
“ Paralysis of Seventh Nerve. J. R. Lane.....	335
“ Pemphigus.....	167
“ Pemphigus, Congenital. C. C. Lee.....	205
“ Stricture of Rectum. Marshall.....	186
“ Ulceration of Throat, Treatment by Sulphurous Acid. Purdon..	89
“ “ Treatment by Sulphurous Acid. Murchison.....	186
“ Ulcers cured by Calomel Fumigation. Pick.....	372
“ Waxy Liver, Treatment. Wetzlar.....	88
“ Women, proportion of Abortions in. Weber.....	339
Syphilization. W. Boeck.....	7
Tarry Applications in Treatment of Skin Diseases. Anderson.....	178
TAYLOR, ROBERT W. On Serpiginous Tubercular Syphilide.....	23
“ “ Papular Syphilides.....	105
Testis, Fungous Disease of, with Encephaloid Cancer of Liver. Rooke...	344
“ use of Ice in Affections of Testicular Apparatus. P. Diday.....	48
Tinea, Treatment. Fox.....	271
“ Circinata of Hand. Fox.....	352
“ Favosa, Treatment with Alcoholic Fomentation. Cantoni.....	280
Tracheotomy in Syphilitic Affections of Respiratory Passages. Trélat....	82
Tubercle, Syphilis as a Cause of. Lebert.....	157
Ulcer, Tuberculous, of Mouth and Tongue. Trélat.....	154
Ulceration of Palate in Young Subjects. Hutchinson.....	240
Urethral Discharges, Treatment of Chronic. Otis.....	263
Urticaria complicating Small-Pox. Gabler.....	355
Vaccino-Syphilitic Inoculation. F. P. Foster.....	189, 293
VAN BUREN, WILLIAM H., Contribution to the study of Congenital Syphilis.	17
Varices of Superficial Lymphatic Plexus of Penis and Scrotum. Trélat....	169
Warts, Removal of.....	88
WEIR, ROBERT F. Use of Endoscope in difficult Strictures of Urethra,....	32
WEISSE, FANEUIL D. On the Topical Treatment of Lupus Serpiginosus....	316
ZINSSER, FREDRICK. On the Doctrines of Unicism and Dualism of the Syphilitic Contagion.....	220





